



*In alliance with
The University of Vermont*

Fletcher Allen Preferred Plus Medical Plan

Plan Document

Effective January 1, 2002

Revised Effective January 2011

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INTRODUCTION

Your health...you depend on it, try to protect it and, we hope, do not take it for granted. You can do a lot to minimize your chances of illness or injury, but if you need treatment, you want to know you can get the help you need.

That's why Fletcher Allen Health Care offers medical care benefits, to help protect your health with comprehensive coverage. These benefits can help you get the treatment you need and want for your own and your family's health.

Your **Fletcher Allen Preferred Plus Medical Plan** benefits are described in this booklet. A benefit summary, called Medical Plan Highlights, appears in the next few pages.

This booklet is a summary plan description of your Fletcher Allen Preferred Plus Medical Plan medical care benefits; it also serves as the full Plan Document. It does not contain all details of medical policy that guide utilization review decisions. These are available upon request from Vermont Managed Care.

This booklet is neither a contract of current or future employment, nor does it guarantee payment of benefits.

Fletcher Allen Health Care reserves the right to amend or terminate the benefits described in this booklet or to change the amount of Employee contributions at any time, to the extent permitted by law.

Benefits described in this document are effective January 1, 2002, and revised on January 1, 2006, January 1, 2010, and January 1, 2011. Technical terms are capitalized and defined in the Definitions section.

MEDICAL PLAN HIGHLIGHTS

This is a summary of your Fletcher Allen Preferred Plus Medical Plan benefits. This Plan combines medical and mental health and substance abuse services. You receive preferred benefits only when you use the Participating Providers in the Vermont Managed Care Provider Network, pharmacies participating in the CIGNA Healthcare Prescription Drug Program, and behavioral health providers participating in the CIGNA Behavioral Health Network.

This is an open access plan. Primary Care Physician referrals are not required. However, necessary **Pre-Approval** is required for certain medical procedures and treatment (see Pre-Approval section on pages 24-25).

Fletcher Allen Preferred Medical Plan <i>(Open Access-No Primary Care Physician Referrals Required)</i>		
Benefits/Services	In-Network Coverage	Out-of-Network Coverage
Lifetime Maximum	Unlimited, except as noted for specific services	Unlimited, except as noted for specific services
Annual Deductible (Individual/Family) - Includes Medical Services and Mental Health/Substance Abuse Services (Includes coinsurance; does not include copayments)	\$250 per Participant/\$750 per family	\$500 per Participant/\$1,500 per family
Annual Out-of-Pocket Maximum (Individual/Family)	\$1,500/\$4,500 - Includes coinsurance and deductible	\$2,000/\$6,000 Includes coinsurance and deductible
Pre-Existing Condition Limitation	None	None

Benefits/Services	In-Network Coverage	Out-of-Network Coverage
<u>Office Visits</u> <ul style="list-style-type: none"> • Copayment Primary Care • Copayment Specialists • Coinsurance (you pay/Plan pays) 	\$10 \$25 0%/100%	\$0 \$0 30%/70%
<u>Preventive Care</u> <ul style="list-style-type: none"> • Copayment for Primary Care • Coinsurance (you pay/Plan pays) • Colorectal Screening 	\$0 0%/100% \$0	Not Covered
<u>Maternity</u> <ul style="list-style-type: none"> • Copayment for Office visit to Confirm Pregnancy • Copayment for Prenatal/Postnatal Visits • Copayment for other Specialist visits • Coinsurance (you pay/Plan pays) 	\$10 \$0 \$25 0%/100%	\$0 \$0 \$0 30%/70%
<u>Inpatient Hospital (Medical)</u> <ul style="list-style-type: none"> • Copayment • Coinsurance (you pay/Plan pays)- FAHC • Coinsurance (you pay/Plan pays)- Non-FAHC 	\$0 5%/95% 10%/90%	\$0 Not Applicable 30%/70%
<u>Outpatient Surgery</u> <ul style="list-style-type: none"> • Coinsurance (you pay/Plan pays)- FAHC • Coinsurance (you pay/Plan pays)- Non-FAHC • Office Surgery Copayment • Office Surgery Coinsurance (you pay/Plan pays) • Coinsurance for Surgeon Fees (you pay/Plan pays)- FAHC • Coinsurance for Surgeon Fees (you pay/Plan pays)- Non-FAHC • Second Opinion Copayment • Second Opinion Coinsurance (you pay/Plan pays) • Colonoscopy Diagnostic Copayment 	5%/95% 10%/90% \$25 0%/100% 5%/95% 10%/90% \$25 0%/100% \$10	Not Applicable 30%/70% \$0 30%/70% Not Applicable 30%/70% \$0 30%/70% \$10

Benefits/Services	In-Network Coverage	Out-of-Network Coverage
<p><u>X-ray and Laboratory Services</u> <u>Diagnostic:</u> (includes outpatient CT, MRI, Nuclear Scans)</p> <ul style="list-style-type: none"> • Coinsurance (you pay/Plan pays)- FAHC • Coinsurance (you pay/Plan pays) - Non-FAHC <p><u>Preventive, X-ray, Imaging and Laboratory Services:</u></p> <ul style="list-style-type: none"> • Coinsurance (you pay/Plan pays) 	<p>5%/95%</p> <p>10%/90%</p> <p>0%/100%</p>	<p>Not Applicable</p> <p>30%/70%</p> <p>Not Covered</p>
<p><u>Emergency Services (including Emergency Services for Mental Health/Substance Abuse):</u> Coinsurance will also apply for testing for specific additional services.</p> <ul style="list-style-type: none"> • Copayment for Emergency Room • Coinsurance for Ambulance – Emergency (you pay/Plan pays); • Non-emergent Ambulance 	<p>\$50 (waived if admitted) 0%/100%</p> <p>Not covered</p>	<p>\$50 (waived if admitted) 0%/100%</p> <p>Not covered</p>
<p><u>Urgent Care or Walk-In Care Center</u> Coinsurance will also apply for testing for specific additional services.</p> <ul style="list-style-type: none"> • Copayment 	<p>\$25</p>	<p>\$25</p>

Benefits/Services	In-Network Coverage	Out-of-Network Coverage
<p><u>Infertility</u></p> <ul style="list-style-type: none"> • Office Visit Copayment (for evaluation and testing only) • Office Visit Coinsurance (you pay/Plan pays) • Surgery Coinsurance (you pay/Plan pays) <p>Note: For services below, must use a FAHC Provider:</p> <ul style="list-style-type: none"> • Infertility treatment Coinsurance (you pay/Plan pays) <ul style="list-style-type: none"> • Artificial Insemination • Intra-Uterine Insemination • In Vitro Fertilization • Lifetime Maximum Benefit for infertility treatment <p><u>NOTE:</u> Infertility treatment services are exempt from the Annual Deductible and do not contribute to the Annual Out-of-Pocket Maximum.</p>	<p>\$25</p> <p>0%/100%</p> <p>5%/95%</p> <p>50%/50%</p> <p>\$15,000</p>	<p>\$0</p> <p>30%70%</p> <p>30%70%</p> <p>Not Covered</p> <p>Not Covered</p>
<p><u>Outpatient Rehabilitation (Physical, Speech, and Occupational Therapies for short term, acute care)</u></p> <ul style="list-style-type: none"> • Copayment-FAHC Provider • Copayment –Non-FAHC Provider • Coinsurance (you pay/Plan pays) • Combined Maximum Annual Benefit Allowed Under Plan, inclusive of in-network and Out-of-Network care 	<p>\$10</p> <p>\$25</p> <p>0%/100%</p> <p>30 visits</p>	<p>Not Applicable</p> <p>\$0</p> <p>30%70%</p> <p>30 visits</p>

Benefits/Services	In-Network Coverage	Out-of-Network Coverage
<p><u>Special Services</u></p> <p><i>Skilled Nursing Facility</i></p> <ul style="list-style-type: none"> • Copayment • Coinsurance (you pay/Plan pays) • Maximum Annual Benefit Allowed Under Plan <p><i>Home Health Care</i></p> <ul style="list-style-type: none"> • Copayment • Coinsurance (you pay/Plan pays) <p><i>Hospice</i></p> <ul style="list-style-type: none"> • Copayment • Inpatient Coinsurance (you pay/Plan pays) • Outpatient Coinsurance (you pay/Plan pays) 	<p style="text-align: center;">\$0</p> <p style="text-align: center;">10%/90%</p> <p style="text-align: center;">120 days</p> <p style="text-align: center;">\$0</p> <p style="text-align: center;">10%/90%</p> <p style="text-align: center;">\$0</p> <p style="text-align: center;">0%/100%</p> <p style="text-align: center;">0%/100%</p>	<p style="text-align: center;">\$0</p> <p style="text-align: center;">30%/70%</p> <p style="text-align: center;">120 days</p> <p style="text-align: center;">\$0</p> <p style="text-align: center;">30% 70%</p> <p style="text-align: center;">\$0</p> <p style="text-align: center;">30%/70%</p> <p style="text-align: center;">30% 70%</p>
<p><u>Chiropractic Care</u></p> <ul style="list-style-type: none"> • Copayment • Coinsurance (you pay/Plan pays) • Maximum number of visits per Plan Year, inclusive of in-network and Out-of-Network care. <p>\$40 Plan benefit limit applies (Plan pays \$15 per visit).</p>	<p style="text-align: center;">\$25</p> <p style="text-align: center;">0%/100%</p> <p style="text-align: center;">12 visits</p>	<p style="text-align: center;">\$25</p> <p style="text-align: center;">0%/100%</p> <p style="text-align: center;">12 visits</p>
<p><u>Routine Vision Exam</u></p> <ul style="list-style-type: none"> • Copayment • Coinsurance (you pay/Plan pays) • Maximum Benefit Allowed Under Plan 	<p style="text-align: center;">\$0</p> <p style="text-align: center;">0%/100%</p> <p style="text-align: center;">1 visit every 24 months</p>	<p style="text-align: center;">Not Covered</p>
<p><u>Non-surgical TMJ (Temporomandibular Joint) Treatment</u></p> <ul style="list-style-type: none"> • Copayment • Coinsurance (you pay/Plan pays) 	<p style="text-align: center;">\$25</p> <p style="text-align: center;">0%/100%</p>	<p style="text-align: center;">0%</p> <p style="text-align: center;">30% 70%</p>

Benefits/Services	In-Network Coverage	Out-of-Network Coverage
<p><u>Durable Medical Equipment/External Prosthetic Devices</u></p> <ul style="list-style-type: none"> • Copayment • Coinsurance (you pay/Plan pays) 	<p>\$0 20%/80%</p>	<p>\$0 30%/70%</p>
<p><u>Prescription Drug - No Deductible Retail (30 Day Supply)</u> When using a FAHC Pharmacy you may get a 90 day supply for the 60 day supply Copayment</p> <ul style="list-style-type: none"> • Tier 1 generic • Tier 2 preferred • Tier 3 non-preferred <p><u>Infertility Drugs – No Deductible</u></p> <ul style="list-style-type: none"> • Coinsurance (you pay/Plan pays) • Maximum Annual Benefit (Plan Pays) <p><u>NOTE: Infertility treatment services are exempt from the Annual Deductible and do not contribute to the Annual Out-of-Pocket Maximum.</u></p> <p><u>Mail Order Delivery (up to 90 day supply)</u></p> <ul style="list-style-type: none"> • Tier 1 generic • Tier 2 preferred • Tier 3 non-preferred 	<p><u>Copayment</u></p> <p>\$10 \$25 \$45</p> <p>50%/50% \$2,000</p> <p>\$20 \$50 \$90</p>	<p><u>Coinsurance (you pay/Plan pays)</u></p> <p>50%/50% 50%/50% 50%/50%</p> <p>50%/50% \$2,000</p> <p>\$0 \$0 \$0</p>

Benefits/Services	In-Network Coverage	Out-of-Network Coverage
<p><u>Mental Health/Substance Abuse</u> <u>Inpatient</u></p> <ul style="list-style-type: none"> • Copayment • Coinsurance (you pay/Plan pays) – FAHC • Coinsurance (you pay/Plan pays) – Non-FAHC <p><u>Residential and Partial Hospital-</u></p> <ul style="list-style-type: none"> • Copayment • Coinsurance (you pay/Plan pays) – FAHC • Coinsurance (you pay/Plan pays) – Non-FAHC <p>Annual Calendar Year Limit</p>	<p>\$0 5%/95%</p> <p>10%/90%</p> <p>\$0 5%/95%</p> <p>10%/90%</p> <p>None</p>	<p>\$0 Not Applicable</p> <p>30% 70% (No deductible)</p> <p>\$0 Not Applicable</p> <p>30% 70%</p> <p>None</p>
<p><u>Mental Health/Substance Abuse</u> <u>Outpatient; Office Visit</u></p> <p><u>Outpatient/Individual Therapy</u></p> <ul style="list-style-type: none"> • Copayment • Coinsurance (you pay/Plan pays) <p><u>Group Therapy</u></p> <ul style="list-style-type: none"> • Copayment • Coinsurance (you pay/Plan pays) <p><u>Intensive Outpatient Treatment Programs</u></p> <ul style="list-style-type: none"> • Copayment • Coinsurance (you pay/Plan pays) 	<p>\$10 0%/100%</p> <p>\$10 0%/100%</p> <p>\$10 0%/100%</p>	<p>\$0 30% 70%</p> <p>\$0 30% 70%</p> <p>\$0 30% 70%</p>

See “Services Not Covered” on pages 41-47

IMPORTANT NOTE:

The Plan's payment is based on the Allowable Amount for Participating Providers, as determined by the Plan's contract with the Participating Providers to provide covered services to Participants. If you receive services from a non-Participating Provider, even if those services are Pre-Approved, you may be responsible for charge balances above the Reasonable and Customary Charge.

WHO IS ELIGIBLE

Fletcher Allen Health Care offers medical coverage to all full-time and part-time Employees regularly scheduled to work at least 40 hours per pay period. Medical coverage under the Plan, however, is not available to Employees classified as Per Diem (including hourly, on-call, non-benefit-eligible Employees) and Regularly Scheduled Special (RSS) Employees.

Members of your family may also be eligible for coverage. Eligible family members include:

- ◆ Your spouse (as recognized under applicable state law)
- ◆ Your partner under a Vermont Civil Union.
- ◆ Your natural and/or legally adopted child (including a child placed for adoption during the waiting period before adoption becomes final) or stepchild or child of whom you have legal custody (including a foster child) who are younger than age 19. A child is eligible for coverage through the last day of the month during which s/he reaches age 19. Proof of the child's age must be submitted to Vermont Managed Care prior to the date that s/he is enrolled for coverage under the Plan.
- ◆ Notwithstanding the above, your natural and/or legally adopted child, or stepchild or child of whom you have legal custody (including a foster child), who are between the ages of 19 and 26 (including the period through the end of the month during which he/she turns age 26) may retain coverage if they are not eligible to be covered under his/her employer's or spouse's or civil union partner's plan.
- ◆ Any physically or mentally handicapped child, who is dependent on you for support, and whose handicap began before age 19. A child is considered handicapped if s/he is a child who is incapable of self-support due to mental or physical illness or injury. A Physician must certify the physical or mental handicap including the incapability of self-support. The Plan may require a Physician's certification annually.
- ◆ A child may also include your child who meets the requirements in one of the above paragraphs, but is not chiefly dependent on you for support or maintenance if the child is recognized under a qualified medical child support order ("QMCSO") as having a right to enrollment under the Plan. Participants can obtain, without charge, a copy of the Plan's procedures governing QMCSOs from the Plan Administrator.

If you have reached your normal retirement date as defined by the Social Security Administration and are still actively employed in a benefit-eligible status, you will be covered by this Plan for the same benefits as would apply for a person under age 65 who is not eligible for Medicare. See pages 51-52 for further explanation on “Coordination of Benefits” under Medicare.

Except as described below in the section entitled “Continuation of Coverage During Military Leave (USERRA)” (and except to the extent otherwise required by law), any person actively serving in the armed forces of any country is not eligible for coverage under this Plan.

NOTE: *If you and your spouse are the same sex, any benefits provided to your spouse may be taxable, unless your spouse is also your dependent as defined under applicable tax law. Benefits provided to a Vermont Civil Union partner may also be taxable unless your Vermont Civil Union partner is also your dependent as defined under applicable tax law.*

NOTE: *An Employee who is eligible for benefits under this Plan and who is married to, or is a civil union partner of, another eligible Fletcher Allen Health Care Employee may not be covered as an Employee and family member under this Plan at the same time. If more than one family member is eligible for medical benefits under this Plan, the family member must elect either single coverage as the eligible Employee, or be listed as a dependent under the other eligible Employee’s (spouse’s or civil union partner’s) Plan.*

**HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT
OF 1996 (HIPAA)**

Under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), an individual may use his or her previous health insurance coverage to reduce or eliminate any pre-existing condition exclusion period that might be imposed by a new health plan.

When your Plan coverage ends, you and/or your family members are entitled by law to, and will be provided with, a "Certificate of Creditable Coverage." Certificates of Creditable Coverage indicate the period of time you and/or your family members were covered under the Plan (including COBRA coverage), as well as certain additional information required by law. The Certificate of Creditable Coverage may be necessary if you and/or your family members become eligible for coverage under another group health plan, or if you buy a health insurance policy within sixty-three (63) days after your coverage under this Plan ends (including COBRA coverage). The Certificate of Creditable Coverage is necessary because it may reduce any exclusion for pre-existing coverage periods that may apply to you and/or your family members under the new group health plan or health insurance policy.

Certificates of Creditable Coverage will be provided automatically to all covered individuals who lose coverage under this Plan when one of the following applies:

- ◆ An individual who is not a COBRA qualified beneficiary – a Certificate will be provided at the time the individual ceased to be covered under the Plan
- ◆ An individual who is a COBRA qualified beneficiary – a Certificate will be provided at the time of the COBRA event, such as termination of employment, divorce or death, no later than the time a COBRA notice is required to be provided for such qualifying event
- ◆ A COBRA qualified beneficiary who has elected COBRA coverage – a Certificate will be provided at the time COBRA coverage ceases, or, if

applicable, after the expiration of any grace period for the payment of COBRA premiums

- ◆ On your request, any time within twenty-four (24) months after your Plan coverage ends

Call Vermont Managed Care at (802) 847-4862 to request a HIPAA Certificate of Creditable Coverage.

WHEN COVERAGE BEGINS

You and your eligible family members are eligible for coverage on the first of the month following your date of hire or you change to a benefit eligible status. If your hire date or the date you change to a benefit eligible status is coincident with the first day of any month, your coverage will become effective that day. You must enroll in the Plan before coverage can begin. Instructions on the proper enrollment process are available from the Fletcher Allen Health Care Benefits Department.

Residents and their eligible family members are eligible for coverage commencing on the first recognized day of their respective programs, per the Accreditation Council Graduate Medical Education (ACGME) Institutional Requirements document dated 7/1/2007 section II.D.4.g.

Eligible Employees and their family members must enroll within thirty-one (31) days of the date the Employee or family member becomes eligible for the Plan; otherwise they are not eligible to enroll in the Plan until the next open enrollment period.

Spouses or civil union partners and stepchildren must enroll within thirty-one (31) days of marriage or civil union. Newborn children must be enrolled within thirty-one (31) days of birth. Newborn children are covered automatically for the first thirty-one (31) days if the mother or father is enrolled in the Plan. Newborn children of dependents are not eligible for coverage under this Plan. Adopted, foster or step-children must be enrolled within thirty-one (31) days of the latest of the official adoption date or placement for adoption or relevant court order date.

Important Note: You must complete the proper enrollment process to enroll any new family members, within thirty-one (31) days of date of eligibility,

including newborn children, within thirty-one (31) days of birth. Contact the Fletcher Allen Health Care Benefits Department at (802) 847-2825 to obtain instruction on the process. If you do not enroll your eligible family members within the thirty-one (31) day period, your family member will not be eligible for coverage until the next open enrollment period.

An exception to the rule that postpones enrollment until the next open enrollment period will be made if you elect not to pay the premium at the beginning of your eligibility period because you or your family members had coverage under another plan, but you (or your family members) then lose that coverage because employer contributions cease or because of a loss of eligibility resulting from a change in family status (i.e., legal separation, divorce, termination of employment, reduction in hours, exhaustion of COBRA, a child's aging out of coverage, or moving out of an HMO service area) other than a failure to pay Participant premiums or termination of coverage for cause (such as fraud). In that event, you will be given the opportunity to purchase coverage for your family members and yourself provided that you notify the Plan in writing within thirty-one (31) days of the qualifying event. If the other coverage was COBRA coverage, this exception only applies after the COBRA coverage is exhausted. Finally, an exception may also be made if you acquire a new family member through marriage, civil union, birth, adoption, or the placement of a child for adoption. In that event, you may add the new family member to coverage by providing written notice to the Plan within thirty-one (31) days of the marriage, civil union, birth, adoption or placement of a child for adoption. Coverage for you or your family members confined to a Hospital or Skilled Nursing Facility on the day coverage would otherwise become effective will become effective when any prior medical coverage ends.

MAKING CHANGES IN YOUR COVERAGE

Before the beginning of each Plan Year, Fletcher Allen Health Care reviews the costs associated with maintaining the Plan and will announce the Participant contributions required for medical coverage for the coming calendar year. You will then have the opportunity during the annual open enrollment period to decide what level of coverage you want for yourself and your family members for the coming year.

Once you select the level of coverage for a Plan Year, you generally may not change your coverage during the Plan Year unless you experience a qualified change in your family or employment status. By law, family status changes must be reported within thirty-one (31) days of the event and include (but are not limited to):

- ◆ Marriage, civil union or divorce
- ◆ Birth, change in custody or adoption of a child (including placement for adoption of a child), placement of foster child or step-children
- ◆ Changes in your spouse's or civil union partner's employment
- ◆ Death or disability of you or a family member covered under the Plan
- ◆ Change in employment status (for example, termination or commencement of employment, or switching from full-time to part-time, or vice versa by you or your spouse or civil union partner)
- ◆ Taking an approved unpaid leave of absence by you or your spouse or civil union partner
- ◆ The issuance of a "qualified medical child support order" (QMCSO) from a state court directing the Plan Administrator to provide Plan coverage to a child for benefits
- ◆ Loss of other health coverage

In the absence of a "qualifying event" as described above, you are not permitted to change your coverage election during the year, but rather, only during the next annual open enrollment period.

HOW MEDICAL COVERAGE WORKS

When you obtain services from a Participating Provider, this is how medical coverage works:

- ◆ Once you fulfill the Deductible requirement(s), you pay --

a Copayment for certain services
(See Medical Plan Highlights on pages 2-9)

- ◆ After the Copayment (if required), the Plan pays--

100% of covered services not requiring Coinsurance, or the specified percentage of covered services requiring Coinsurance

- ◆ If Coinsurance is required --

You share the cost with the Plan
(See Medical Plan Highlights on pages 2-9)

- ◆ When your share of expenses reaches your Out-of-Pocket Maximum

Plan pays 100% of the Allowed Amount for the rest of your covered services, (excluding Copayments or amounts above Plan maximums) for the remainder of the Plan Year

If you obtain medical services from a non-Participating Provider, you will be covered at the Out-of-Network coverage level as outlined in the Medical Plan Highlights section of this document once you have met your annual deductible, except for Emergency Services or where Vermont Managed Care provides written Pre-Approval.

Out-of-Network non-emergent services may be considered for approval for Plan preferred benefits coverage if those services are Medically Necessary, are a Covered Service, and cannot be provided by any Participating Provider.

NOTE: The Plan's payment is the Allowed Amount determined by the Plan for the covered services provided. If you receive services from a non-Participating Provider, even if those services are Pre-Approved, you may be responsible for charges above the Reasonable and Customary Charge.

Your Copayments

You are responsible for paying to the Provider any applicable Copayment for covered services you receive under the Plan. Copayments vary depending on the type of service and who provides it. Copayment amounts are specified in the Medical Plan Highlights on pages 2-9.

Coinsurance

Coinsurance means that both you and Fletcher Allen Health Care share the cost for medical services rendered. For example, when you use a Fletcher Allen Health Care Provider or facility, you are responsible for paying 5% of the Allowed Amount determined by the Plan for inpatient and outpatient hospital care, diagnostic imaging, laboratory, and outpatient surgery. For all of the above, and home health services, you are responsible for paying 10% when using an in-network non-Fletcher Allen Health Care Provider or facility; other examples of Coinsurance include 50% of the Allowed Amount for infertility treatments (Fletcher Allen Health Care Providers only), 20% of the Allowed Amount for all Durable Medical Equipment items and 30% of the Allowed Amount for Out-of-Network services after Deductibles are met. See the Medical Plan Highlights on pages 2-9 for a complete listing of your Coinsurance obligations.

Deductible

A deductible is the amount of money that you must pay for health care services out-of-pocket before your medical plan will begin paying benefits. This Plan has an In-Network annual Deductible (which includes coinsurance payments) of \$250 per Participant, up to \$750 per family. In-Network primary care services, pharmacy services, Mental Health and Substance Abuse Treatment services, and infertility treatments are exempt from the Deductible.

This Plan has an Out-of-Network annual Deductible (which includes coinsurance payments) of \$500 per Participant, up to \$1,500 per family.

Out-of-Pocket Maximum

For In-Network coverage benefits: After you pay your Deductible and your portion of Coinsurance for certain covered services for you or for your family members up to the maximum designated Out-of-Pocket limit, you pay only the required Copayment for further covered services for the rest of the Plan Year if you (or your family members) use Participating Providers. The Plan then pays 100% of the Allowed Amount for all remaining expenses for the remainder of the Plan Year. The annual Out-of-Pocket Maximum per individual is \$1,500 per individual or a combined \$4,500 for you and your family members using Participating Providers.

For Out-of-Network coverage benefits: After you pay your Deductible and your portion of Coinsurance for certain covered services for you or for your family members up to the maximum designated Out-of-Pocket limit, you pay only the required Copayment for further covered services for the rest of the Plan Year if you (or your family members) use Non-Participating Providers. The Plan then pays 100% of the Allowed Amount for non-Participating Provider covered services for the remainder of the Plan Year. Exception: Emergency Services and Pre-Approved Out-of-Network services for which the applicable Plan procedures have been followed. The annual Out-of-Pocket Maximum is \$2,000 per individual or a combined \$6,000 for you and your family members if using non-Participating Providers.

Covered services for which the Out-of-Pocket Maximum applies include but are not limited to: inpatient or outpatient hospitalization (including for Mental Health and Substance Abuse conditions), diagnostic imaging, laboratory, outpatient surgery, durable medical equipment and home health services.

Copayments, including but not limited to, doctor's office visits, hospitalization, emergency room, medical foods, infertility treatment and drugs, and prescription drugs, do not apply toward and are not subject to the Out-of-Pocket Maximum. Charges exceeding the annual Benefit Maximum do not apply to the Out-of-Pocket Maximum.

Lifetime and Annual Benefit Maximums

Except as provided in this booklet, the maximum benefit you or any of your covered family members can receive during a year or lifetime is not limited.

Some specific areas of coverage are limited as follows:

- ◆ Chiropractic care is limited to twelve (12) visits, per calendar year (\$15 maximum Plan payment per visit)
- ◆ Skilled Nursing Facility coverage is limited to one-hundred-twenty (120) days per calendar year
- ◆ Speech, occupational and physical therapy (including services of an Athletic Trainer) is limited to thirty (30) combined visits per calendar year
- ◆ Routine vision exam is limited to one visit every twenty-four (24) months
- ◆ Nutritional counseling is limited to a maximum of three (3) visits per diagnosis per lifetime
- ◆ Medical foods for inherited metabolic disorders are limited to a maximum of \$2,500 per year of Allowed Amount payments, excluding your out-of-pocket expenses; Pre-Approval is required
- ◆ Infertility treatment is limited to \$15,000 per lifetime of Allowed Amount payments, excluding your out-of-pocket expenses; exempt from the Annual Deductible; does not accrue to the Annual Out-of-Pocket Maximum
- ◆ Infertility drugs are subject to an annual \$2,000 limit of Allowed Amount payments, excluding your out-of-pocket expenses; exempt from the Annual Deductible; do not accrue to the Annual Out-of-Pocket Maximum

Medically Necessary

For benefits to apply under the Plan, items or services rendered must be Medically Necessary for the diagnosis and treatment of Injury or Sickness and professionally accepted based on published medical evidence as necessary for your treatment and prescribed or ordered by a Provider or other qualified healthcare provider. See "Pre-Approval" section of this booklet for more information on pages 24-25.

Covered Services

Certain expenses are covered by the Plan, others are not. A guide to covered services can be found in the “Covered Services” section of this booklet on pages 31-38. A guide to services not covered by the Plan can be found under the “Services Not Covered” section of this booklet on pages 41-47. Please call Vermont Managed Care at (802) 847-4862 or toll free at (866) 582-6836 for specific questions regarding your coverage.

USING YOUR COVERAGE

When you enroll, you may access a directory of the Participating Providers in your area on the Fletcher Allen Preferred Medical Plan web site (www.fahcpREFERRED.org). This directory includes Participating Provider addresses, telephone numbers and specialties. It also includes links to websites for Vermont Managed Care, CIGNA Behavioral Health and CIGNA Prescription Drug Program. Paper directories are available, without charge, by calling the number on the back of your ID card (802) 847-4862 or toll free at 1-866-582-6836. You must enroll with a Primary Care Physician in the VMC Provider Network, but may use any Participating Provider listed in the directory. Generally you must use a Participating Provider to be covered at the In-Network benefit level under the Plan. Benefits are paid only for Medically Necessary services from these Participating Providers except where Out-of-Network Emergency Services are used or when written Pre-Approval is obtained. Make sure that you show your membership identification card when you visit a Participating Provider.

Note: Your medical Plan identification number is your Fletcher Allen Health Care Employee number preceded by "FA". If you do not know your Employee identification number, you may call the Fletcher Allen Health Care Benefits Department for assistance.

Access and referral to the CIGNA Behavioral Health Network of Mental Health and Substance Abuse Treatment Providers is available to you on the CIGNA Behavioral Health website: www.cignabehavioral.com or by calling (800) 554-6931.

In cases where Urgent Care or Emergency Services are required, you may need to use a non-Participating Provider. In these cases, benefits will be paid as if you had used a Participating Provider as described in this booklet. For Medical

Hospital Confinement/Emergency Services, you (or a member of your family or your medical services provider) must notify Vermont Managed Care of your admission to a non-Participating Provider within forty-eight (48) hours of admission to receive coverage under the Plan. Vermont Managed Care may be contacted at (802) 847-4862 or toll free at (866) 582-6836.

Pre-approval for Mental Health and Substance Abuse Treatments is required for all residential care programs; notification must be received within forty-eight (48) hours of treatment. CIGNA Behavioral Health may be contacted toll free at (800) 554-6931.

PRE-APPROVAL PROGRAM

The Pre-Approval program helps you and your family members avoid unnecessary services and overly long hospitalization by helping you explore medically appropriate, convenient and less costly alternatives. The Pre-Approval program is managed by Vermont Managed Care for medical services, CIGNA Behavioral Health for Mental Health and Substance Abuse Services, and CIGNA Prescription Drug Program for prescription drugs, although similar standards are used for all Pre-Approval programs. *Please refer to the “Pre-Approval and Concurrent Review” section of this booklet on pages 26-30 for a list of procedures that require Pre-Approval under the Plan. Failure to comply with the Plan’s Pre-Approval requirements may result in denial or limitation of coverage under the Plan.*

Your Provider should complete the Pre-Approval process as soon as possible, but generally no later than five (5) working days before you receive one of the services listed in the “Pre-Approval and Concurrent Review” section of this booklet or before a Hospital Confinement. To assure timely notification, you may contact Vermont Managed Care at (802) 847-4862 or toll free at (866) 582-6836 or CIGNA Behavioral Health at (800) 554-6931. You are responsible for making sure that your Provider submits the request. You, your Provider and the Hospital will be notified of the Pre-Approval decision within fifteen (15) days after receipt of the request. In special circumstances, a response to your request for Pre-Approval may take more than fifteen (15) days. If an extension is needed, you will receive written notice before the end of the fifteen (15) day period. In no event will the extension be more than fifteen (15) days.

Pre-Approval for Urgent Medical Care Claims

For Pre-Approval requests for Claims Involving Urgent Care, Vermont Managed Care will notify you and your Provider of the Pre-Approval decision

within seventy-two (72) hours of receipt of the request for services. If Vermont Managed Care does not receive all of the information necessary to consider the request for Pre-Approval, Vermont Managed Care will notify you and your Provider of the information needed to complete its review. Within twenty-four (24) hours of receipt of the requested information, Vermont Managed Care will notify you and your Provider of the Pre-Approval decision.

If your Hospital admission or treatment is not approved, you or your Provider may appeal the decision. See the “Appeals Policy” section of this booklet on pages 80-89 for instructions on the appeals process.

Pre-Approval for Urgent Mental Health and Substance Abuse Treatment Claims

For Pre-Approval requests for Mental Health and Substance Abuse Treatment Claims Involving Urged Care, CIGNA Behavioral Health will notify you and your provider of the Pre-Approval decision within seventy-two (72) hours of receipt of the request for services. If CIGNA Behavioral Health does not receive all of the information necessary to consider the request for Pre-Approval, CIGNA Behavioral Health will notify you and your Provider of the information needed to complete its review. Within twenty-four (24) hours of receipt of the requested information, CIGNA Behavioral Health will notify you and your Provider of the Pre-Approval decision. If your Hospital admission or treatment is not approved, you or your Provider may appeal the decision. See the “Appeals Policy” section of this booklet on pages 87-88 for instructions on the appeals process applicable to Urgent Mental Health and Substance Abuse Treatment Claims.

PRE-APPROVAL AND CONCURRENT REVIEW

The Plan pays benefits for certain services only if you and your Provider follow the Pre-Approval and concurrent (ongoing) review program procedures. Failure to comply with these procedures may result in denial of benefit coverage under the Plan. Pages 29 and 30 include a list of services that require Pre-Approval. However, please refer to the lists of Covered Services and Services Not Covered to see if Pre-Approval is required. Call Vermont Managed Care if you have any questions.

Inpatient Pre-Approval and Concurrent Review

Unnecessary hospitalization is costly and can pose needless risks to your health. To help prevent this, non-emergency hospitalizations must be pre-approved through the Pre-Approval program for regular benefit payment at least five (5) working days ahead of the admission date if possible. Ongoing reviews are conducted throughout your Hospital stay by Registered Nurse case managers to ensure that medical resources are efficiently used. Pre-Approval and ongoing reviews are handled by Vermont Managed Care, Care Management Department.

If your Provider recommends that you or a family member be hospitalized, you or your Provider must call Vermont Managed Care for Pre-Approval. **Failure to comply with the Plan's Pre-Approval procedures may result in a loss or limitation of coverage under the Plan.**

***Call Vermont Managed Care to obtain Pre-Approval
for a Hospital stay at (802) 847-4862 or toll free at (866) 582-6836
24 hours a day, 7 days a week to receive coverage under the Plan***

Vermont Managed Care's telephone number is printed on the back of your medical Plan identification card. In the case of an Emergency Hospital Confinement, you or your Provider must call Vermont Managed Care within forty-eight (48) hours of admission. If you ask your Provider or someone else

to call Vermont Managed Care for you - and that person fails to do so - you may be responsible for the cost of any services not paid for by the Plan and any financial penalties imposed by the Plan.

The concurrent review program Nurses will conduct ongoing reviews with your Provider throughout your Hospital stay. The Plan pays regular benefits only for the length of stay approved by Vermont Managed Care. Benefits for non-approved Hospital stays may be reduced or denied.

Mental Health and Substance Abuse Inpatient Pre-Approval and Concurrent Review

Pre-Approval is required for non-emergency inpatient and residential care. In the case of an Emergency Hospital Confinement, at an in-Network facility or program, notification must be received within seventy-two (72) hours of the admission to be covered at in-Network benefit levels. In the case of an Emergency Hospital Confinement at an Out-of- Network facility, notification must be received within seventy-two (72) hours of the admission to ensure coverage.

Non-Emergency Inpatient, Partial Hospital and Intensive Outpatient Treatment for Mental Health and Alcohol or Drug Abuse must be Pre-Approved through CIGNA Behavioral Healthcare (CBH) by calling (800) 554-6931 24 hours a day, 7 days a week

Outpatient Procedures Requiring Pre-Approval by Vermont Managed Care

The list below includes diagnostic and therapeutic procedures which are sometimes done on an outpatient basis. When done electively or on an outpatient basis, these procedures require authorization by Vermont Managed Care's Care Management Department. Call to request Pre-Approval at least five (5) or more business days before a planned elective procedure if possible. Call within forty-eight (48) hours after an emergency procedure or on the morning of

the next business day after a holiday or weekend emergency procedure or facility admission.

When you call Vermont Managed Care, please have the following information readily available:

- ◆ Provider's name, address and phone number
- ◆ Diagnosis and/or procedure planned (see table on following page)
- ◆ Patient's name, address, phone number, member ID number, and birth date
- ◆ Employee's name, address, phone number and member ID number
- ◆ Name, phone number and address of the Hospital or outpatient procedure center
- ◆ Planned date of service or admission date

Please be prepared to indicate the reason for your request and any supporting medical information: i.e., laboratory, radiology, clinical notes and/or consultation reports.

PROCEDURES REQUIRING PRE-APPROVAL	
General:	Drug Therapy:
All cosmetic or reconstructive procedures	Amevive
All non-emergency inpatient admissions	Botulinum toxin treatment
All requests for non-emergent Out-of-Network services	Flolan
All Home Health Care	Gamma globulin for polyneuropathy
All Hospice Care	Viagra
All Skilled Nursing Facility Care	
All Experimental/Investigational services. (Experimental/Investigational services are generally excluded)	Genzyme, Cerazyme
Medical:	Gaucher's disease treatment
Air medical transport	GnRH, Lupron, Zolodex
Cardiac and pulmonary rehabilitation	Growth Hormone
Dialysis (renal or peritoneal)	Hemophila factor
Enteral therapy	Hepatitis B vaccine (over age 18)
Genetic counseling and testing	Interleuken-2
Hyperbaric O ₂ (HBO)	Lymexix vaccine
Neuropsychological evaluation and testing	Mitoxantrone forms
Pain management programs	Peg intron
Psoriasis treatment/PUVA Lights	Prevnar (over 24 mos. of age)
Pulmonary rehabilitation	Remicade
Surgical:	Synagis
Breast augmentation/reduction surgery	Durable Medical Equipment (DME) – all DME with cost greater than \$500, all rental equipment, including but not limited to:
Breast surgery in males	
Circumcision	
Dermabrasion	
**Diagnostic laparoscopy	Continuous passive motion devices
** Hysterectomy	Dorsal column stimulator
Infertility correction	Breast prostheses
Laser treatments: example: port wine stains/ rosacea	Electrical bone stimulator
Organ/Stem cell/Bone marrow transplant	Electric wheelchair/scooters

Surgical: Cont.	DME: Cont.
Orthognathic surgery related to TMJ	Erectile dysfunction devices
Rhinoplasty	Ankle/Foot orthotics
Sclerotherapy	Insulin pump and supplies
** Septoplasty	Light therapy for seasonal affective disorder
** Sinus surgery/FESS procedure	Lymphedema pumps
Transplant services	Ocular prostheses
	Oral appliances
Uvulopalatopharyngoplasty (UPPP)	Orthotic devices (braces)
Varicose vein surgery	Pressure garments
Mental Health and Substance Abuse:	Breast pumps
Non-emergency inpatient care	
Residential care	
Diagnostic Testing:	Sacral nerve stimulator for urinary incontinence
**CT, MRI,, Myelogram (Head, Cervical, Lumbar, Sacral),	ThAIRapy vest
**Cardiac MRI, Breast MRI	Vitajet injector
**PET Scans, MRS	Wheelchairs
Video EEG monitoring	Cranial prosthetics (wigs)
Ancillary:	
Speech Therapy	

** Participating Provider is financially liable for failure to obtain Pre-Approval. All others, Participant is financially liable for non-covered balances.

NOTE: All injectable medications purchased through a retail pharmacy under the CIGNA Healthcare Prescription Drug Program benefit require Pre-Approval by calling (800) 622-5579.

COVERED SERVICES

The term “covered services” means the services received by an active Plan Participant or their covered eligible family members that meet the requirements for coverage under the Plan. Charges incurred for such services are considered covered services to the extent that the services or supplies are provided by a Participating Provider or by a non-Participating Provider for Emergency Services (or where Pre-Approval is obtained, or when you are accessing your Out-of-Network benefits) and are Medically Necessary for the treatment of any Injury or Sickness. The following are services and supplies covered by the Plan:

- 1) **Ambulance**: emergency ground transportation of the sick or injured.
 - ◆ Charges for licensed ambulance service to or from the nearest facility where the needed medical care and treatment can be provided unless otherwise approved by Vermont Managed Care.
 - ◆ Between facilities, when ambulance use is Medically Necessary and Pre-Approved.
 - ◆ Air medical transport must be Pre-Approved.

- 2) **Chiropractic Care**
Charges made by a licensed chiropractor for professional services - limited to 12 visits per year. Includes x-rays and diagnostics performed by the chiropractor. Some diagnostic testing requires Pre-Approval.

- 3) **Colorectal Screening**
Charges for colorectal screening provided by a Participating Provider. Services include colonoscopy, sigmoidoscopy, fecal occult blood testing. Regardless of place of service, a copayment of not more than \$10 will apply.

- 4) **Diabetic Pumps and Supplies**
 - ◆ Diabetic insulin pumps are a covered service and are reimbursed as Durable Medical Equipment at 80% of Allowed Amount. Pump Supplies are covered at 100% of Allowed Amount.
 - ◆ Other diabetic supplies are not covered by the medical Plan but may be covered through the prescription drug plan.
 - ◆ Pre-Approval required.

- 5) **Durable Medical Equipment (DME)**

DME which is Medically Necessary for the care of a Sickness or Injury is covered. DME may be rented or purchased. Pre-Approval is necessary for any items with a purchase price of \$500 or more, or **any** rental equipment and external prosthetics.

- ◆ The equipment must meet the following criteria:
 - it is manufactured solely to serve a medical purpose; it is not primarily for comfort or convenience
 - it is ordered by a Provider working within the scope of his/her license
 - it is generally not useful to a Participant in the absence of Sickness or Injury
 - it is appropriate for use in the home
 - it can withstand repeated use

- ◆ Exclusions - including but not limited to:
 - hearing aids
 - air conditioners, humidifiers, dehumidifiers or purifiers, HEPA filters
 - arch supports, shoe insert orthotics, corrective shoes (coverage for these items may be available for diabetics if Pre-Approval is received)
 - blood pressure machines or cuffs
 - heating pads, hot water bottles, disposable items (e.g. rubber gloves)
 - sterile water, distilled water
 - deluxe equipment (e.g., motor driven wheel chair or beds), when standard equipment meets medical need
 - rental or purchase of equipment, when in a facility which provides such equipment
 - stair chairs
 - physical fitness, gym memberships, exercise equipment including isotonic and isometric devices, and ultraviolet/tanning equipment
 - home modifications, for example: seat or chair lifts, elevators, stair glides, "barrier-free" construction
 - automobile modifications, for example: wheelchair lifts or hand accelerator or braking controls
 - breast pumps (consideration may be given with Pre-Approval for the rental of a hospital-grade breast pump for mothers with pre-term or other neonates requiring intensive care hospitalization, or when breast milk has been established to be Medically Necessary for the infant's medical condition and maternal milk production is inadequate with standard breast pumps.)
 - power scooters when use is primarily for use outside the home

- pressure garments, such as compression hose (may be covered with clinical documentation of lymphedema or functionally limiting varicose veins with Pre-Approval; limited to four (4) garments per benefit year)

6) **Emergency Services**

Emergency Services are covered at a Participating Provider facility to the extent that they are Medically Necessary. Emergency Services are subject to Copayments. However, Copayments are waived if an acute Hospital Confinement results. Plan authorization for such service must be obtained within forty-eight (48) hours after the service.

Note:

- ◆ For all Mental Health and Substance Abuse Emergencies, notification should be received by CIGNA Behavioral Health within forty-eight 48 hours of the admission.
- ◆ No Copayments are required for outpatient Emergency Hospital services Out-of-Network.
- ◆ If a Participant visits an Out-of-Network emergency room for non-Emergency Services, no benefits will be provided.
- ◆ The Plan reserves the right to retrospectively review services received in an emergency room to determine whether they were Emergency Services.

7) **Genetic Counseling/Testing** - requires Pre-Approval for Medical Necessity.

8) **Home Health Care** - requires Pre-Approval.

The Plan will provide benefits as detailed in the Medical Plan Highlights (pages 2-9) for home health care charges made by a Home Health Care Agency for the following covered necessary services or supplies provided to a Participant who is homebound:

- ◆ Part-time or intermittent nursing care by a Registered Nurse or by a Licensed Practical Nurse under the supervision of a Registered Nurse;
- ◆ Part-time or intermittent home health aide services which consist primarily of caring for the Participant when skilled services are also in place;
- ◆ Physical therapy, occupational therapy, speech therapy and social work provided by the Home Health Care Agency (accumulates to the combined thirty (30) visit limit); and
- ◆ Medical supplies, laboratory services and medications prescribed by a physician, to the extent such items would have been covered under this Plan if the covered Participant had been confined in a Hospital.

- 9) **Hospice Care** - requires Pre-Approval.
- ◆ Charges made for a Participant who has been diagnosed as having six months or less to live, due to Terminal Illness. The following services are covered under a hospice care program:
 - by a Hospice Facility for services provided on an outpatient basis
 - by a Provider for professional services
 - by a Psychologist or social worker for individual or family counseling including bereavement counseling
 - by a Home Health Care Agency for:
 - part-time intermittent nursing care by or under the supervision of a Nurse
 - part-time intermittent services of a Home Health Aide
 - physical therapy, occupational therapy, speech therapy services (accumulates to the combined 30 visit limit) provided as comfort measures
 - Durable Medical Equipment
 - social worker services
 - IV/IM/SC therapies for hydration, pain management and/or antibiotics
 - epidural pain control
 - continuous care nursing services
 - respite, homemaker services, custodial services
- 10) **Hospital Inpatient Medical Care**
Room and board and other Medically Necessary services and supplies, including inpatient professional visits, surgery, anesthesia, diagnostic imaging, laboratory, chemotherapy, blood transfusions, oxygen therapy, physical therapy, occupational therapy, speech therapy, or respiratory therapy.
- 11) **Hospital Outpatient Medical Care**
Coverage for charges for Medically Necessary surgery, procedures, treatment, supplies and professional services received as an outpatient.
- 12) **Infertility Treatment**
- ◆ For diagnostic testing and evaluation leading to the diagnosis of infertility. Treatment of infertility when a woman's age is less than 42 at time of service (exception: age less than 50 for drugs and donor gamete) provided at Fletcher Allen Health Care within the limits outlined in Medical Plan Highlights on page 5 of this booklet.
 - ◆ Medically Necessary surgical corrective procedures (requires Pre-Approval)
 - Artificial Insemination with donor sperm (AI)
 - Intrauterine Insemination (IUI)

- Oocyte stimulation and retrieval
 - Assisted Hatching
 - In Vitro Fertilization (IVF), including donor oocyte fertilization, up to four (4) cycles
 - Must be done according to American Society for Reproductive Medicine (ASRM) guidelines for number of embryos transferred
 - Intracytoplasmic sperm injection (ICSI)
 - Pharmaceuticals associated with a covered service
 - Preimplantation genetic diagnosis (PGD) for single cell disorders
 - Oocyte and sperm storage
- ◆ Exclusions:
- GIFT (Gamete Intrafallopian Transfer)
 - ZIFT (Zygote Intrafallopian Transfer)

NOTE: Infertility treatment services are exempt from the Annual Deductible and do not contribute to the Annual Out-of-Pocket Maximum.

13) **Mastectomy**

If you have had or are going to have a mastectomy, you may have certain rights under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending Physician and the Participant, for:

- ◆ All stages of reconstruction of the breast on which the mastectomy was performed;
- ◆ Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- ◆ Prostheses; and
- ◆ Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this Plan. Therefore, the following deductibles and coinsurance apply for in-network services: \$10 Copayment for Primary Care, \$25 Copayment for specialist care, 5% Coinsurance for Hospital Confinement at Fletcher Allen Health Care and 10% at non-Fletcher Allen Health Care facilities, 5% coinsurance for outpatient surgical care at a Fletcher Allen Health Care Provider or facility (10% coinsurance at a non-Fletcher Allen Health Care Provider or facility). Refer to the Medical Plan Highlights on pages 2-9 for more complete information on Copayment, Deductibles and Coinsurance and Out-of-Pocket Maximums.

If you would like more information on WHCRA benefits, call Vermont Managed Care, toll-free at 1-866-582-6836 or (802)847-4862.

14) **Maternity and Newborn Services**

The Plan will pay maternity benefits, including treatment for false labor and toxemia of pregnancy, as well as complications from pregnancy. Covered services must be provided by a medical doctor, osteopath or nurse midwife. Services must be received from a VMC Participating Provider to receive In-Network benefit coverage.

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

The Plan covers a newborn child of you or your spouse or civil union partner from the moment of birth for 31 days including benefits for medically diagnosed congenital defects, birth abnormalities and prematurity. The Plan also pays for the initial inpatient examination by a doctor other than the delivering doctor or the doctor who administered the anesthesia. **To continue the child's medical coverage beyond the 31 day period, you must enroll the child for coverage within 31 days of birth. Otherwise, your child will have no coverage after the initial 31 day period.**

Maternity care requires a \$10 Copayment to confirm pregnancy. No further Copayment is required for routine maternity care in the office setting. However, if you should require specialty care services, for example, an amniocentesis, or referral to high-risk maternal-fetal medicine physicians, a specialty care Copayment of \$25 per visit will apply. In some cases, you will also pay 10% coinsurance of any diagnostic testing, X-ray or laboratory fees.

Vermont Managed Care offers a Maternity Wellness Program. This program offers added benefits for expectant parents who voluntarily enroll in the program. For more information contact Vermont Managed Care 802-847-8161 or 1-866-582-6836.

- 15) **Mental Health and Substance Abuse Treatments**
Non-emergency inpatient and residential care requires Pre-Approval; to obtain Pre-Approval, call CIGNA Behavioral Health at (800) 554-6931.
- 16) **Nutritional Counseling**
Medically Necessary visits with a certified nutritionist or dietetic counselor, limited to three (3) visits per diagnosis per lifetime.
- 17) **Office Visits**
- ◆ Professional service provided in an office setting including preventive care, immunizations, injections, pre- and post- natal care and periodic health evaluations
 - ◆ Consulting Providers, second opinions
- Note: Preventive care is covered on an In-Network basis only.**
- 18) **Pain Management Program** - requires Pre-Approval.
- 19) **Prostheses/Prosthetic Medical Appliance**
- ◆ External:
 - which are used as a replacement or substitute for a missing body part and are necessary to alleviate or correct sickness, injury or congenital defect; limited to:
 - artificial upper and lower extremities
 - ocular prosthesis
 - breasts
 - wigs for chemotherapy induced alopecia
- (Pre-Approval required), subject to limitations on Medical Plan Highlights under Durable Medical Equipment (see page 7).
- 20) **Rehabilitation Services**
- ◆ **Inpatient:** - requires Pre-Approval.
 - For all services provided by a licensed acute or sub-acute rehabilitation facility
 - ◆ **Outpatient:**
 - For services of physical therapy, occupational therapy, athletic training, and speech therapy; limited to thirty (30) combined visits per year, inclusive of all outpatient therapies that are Acute in nature and Medically Necessary.

- 21) **Skilled Nursing Facilities (SNF)** - requires Pre-Approval.
- ◆ For inpatient services including:
 - room and board, including nursing care
 - medications provided by SNF
 - all medical services and supplies are included in the pre-established rates of the SNF limited to 120 days per year
- 22) **Transplant Services** - requires Pre-Approval.
- ◆ Charges made for, or in connection with approved solid organ transplant services, including immuno-suppressive medication, organ procurement costs and balance of donor charges which are not covered by the donor's medical insurance plan
 - ◆ Charges made for stem cell or bone marrow transplant services
- 23) **Vision Care**
Maximum benefit is one (1) visit every twenty-four (24) months for routine vision care including refraction performed by a Network eye care provider.
Note: Vision exams are covered on an In-Network basis only.

PRESCRIPTION DRUGS

The Plan covers FDA approved Prescription Drugs and medicines, prescribed by a Provider and dispensed by a licensed Pharmacist and (if you have enrolled in a Plan that covers services only if they are provided by Participating Providers) are purchased at a participating pharmacy.

Covered Drugs

The following items are covered under the Plan:

- ◆ Federal legend drugs (that is, drugs that federal law prohibits dispensing without a prescription) except as excluded below
- ◆ Compound prescriptions containing at least one legend ingredient
- ◆ Insulin
- ◆ Disposable insulin syringes/needles
- ◆ Oral contraceptives/Norplant implant

Drugs Not Covered

The following items are not covered under the Plan:

- ◆ Weight reduction drugs
- ◆ Devices and appliances
- ◆ Over-the-counter items
- ◆ Retin-A (for anyone over age 36)
- ◆ Rogaine (or similar products)
- ◆ Viagra (exception: organic or disease/surgery induced impotence covered when Pre-Approval is obtained)

Brand vs. Generic Drugs

Drugs have two names: a trademark or “brand” name, and a chemical or “generic” name. Many brand-name drugs have a less expensive “generic equivalent” available. Ask your Provider to prescribe generic drugs whenever possible.

By law, brand name and generic drugs must meet the same standards for safety, purity, strength and quality.

Your Cost

DCACTIVE-14491681.1

When you have your prescriptions filled at a CIGNA Healthcare Prescription Drug Program participating retail or mail service pharmacy, you pay a Copayment for Tiers 1, 2 and 3; the Plan pays the rest.

Your Copayments for prescriptions under the Plan are as follows:

- ◆ Up to a 30-day supply obtained through Fletcher Allen Health Care Pharmacies (owned and operated) or CIGNA Network Pharmacies:
 - Tier 1: Generic \$10 copayment
 - Tier 2: Preferred \$25 copayment
 - Tier 3: Non-Preferred \$45 copayment

- ◆ Up to a 90-day supply obtained through Fletcher Allen Health Care Pharmacies (owned and operated) or CIGNA Home Delivery Pharmacy (Mail Service):
 - Tier 1: Generic \$20 copayment
 - Tier 2: Preferred \$50 copayment
 - Tier 3: Non-Preferred \$90 copayment

***NOTE:** Your prescription will be filled for the exact amount prescribed by your Physician, up to the 30 or 90-day supply limit.*

***NOTE:** For more information on the Cigna prescription drug benefit please go to www.myCIGNA.com.*

SERVICES AND CONDITIONS NOT COVERED

Certain expenses are not covered by the Plan and, therefore, are not eligible for payment under the Plan. The following are services and supplies not covered by the Plan. Services and supplies not covered by the Plan are the responsibility of the patient.

- 1) **Alternative or Complementary Therapeutic Practices** including, but not limited to, acupuncture, acupressure, aromatherapy, massage therapy, hypnotherapy, homeopathy, rolfing, reiki, self-help training, and other therapies not specifically listed as covered.
- 2) **Air Ambulance:** when ground ambulance will meet the medical need.
- 3) **Amniocentesis and Ultrasound** or any other procedures requested solely for sex determination of a fetus.
 - ◆ **Exception:** Where Medically Necessary to determine the existence of a sex-linked genetic disorder
- 4) **Charges in excess of Allowed Amount or Reasonable and Customary Charges as determined by the Plan.**
- 5) **Charges submitted by a Provider who is rendering care to himself/herself or his/her family member.**
- 6) **Charges which the Participant is not legally required to pay.**
- 7) **Charges which would not have been made if the Participant had no insurance.**
- 8) **Charges for any item or service not elsewhere listed in this document as a covered benefit.**
- 9) **Chronic care:** Care that is not likely to produce measurable improvement in a reasonable and predictable length of time.
- 10) **Circumcision**
 - ◆ **Exception:**
 - if Medically Necessary, subject to Pre-Approval
- 11) **Cosmetic and Reconstructive Surgery**
 - ◆ **Exception:**
 - to restore function of any body area which has significant impairment from disease, trauma, congenital/developmental

- anomalies or previous therapeutic processes. Subject to Pre-Approval.
- reconstructive surgery following a mastectomy, including surgery and reconstruction of the unaffected breast, for the purpose of achieving symmetry or as otherwise required by federal law. Subject to Pre-Approval.
- 12) **Costs** related to your failure to keep appointments with providers.
- 13) **Court Ordered Treatment/Services**: forensic evaluations or court ordered service.
- 14) **Custodial Care Services and Personal Comfort Items** including but not limited to personal care kits, television and telephone rentals.
- 15) **Dental Care and Oral Surgery** including dental surgery, dental appliances, dental prosthesis, such as crowns, bridges or dentures; implants (including bony preparation for implants), orthodontic care, operative restoration of teeth (fillings); dental extractions; endodontic care; apicoectomies, treatment of dental caries, gingivitis, periodontal disease or other periodontal surgery; vestibuloplasties, alveoplasties, dental procedures involving teeth and their bone or tissue supporting structures, frenulectomy or other dental procedures.
- ◆ **Exception**:
 - Facility and anesthesia charges related to the extraction of bone-impacted wisdom teeth when it is Medically Necessary to have the extraction done at a Hospital, subject to Pre-Approval.
 - Facility and anesthesia charges for pediatric dental work when there is medical record documentation of fear/anxiety/psychological stress that precludes use of an office setting, subject to Pre-Approval.
 - Oral appliances for medical diagnosis of Temporo-Mandibular Joint dysfunction or obstructive sleep apnea, subject to Pre-Approval.
 - Dental work directly related to:
 - Injury to sound natural teeth resulting from trauma (does not include Injury to natural teeth resulting from biting, chewing or bruxism {grinding of teeth})
 - Injury to sound natural teeth resulting from medical treatment for another medical condition, such as cancer chemotherapy or radiation treatments
 - Covered treatment for Injury to sound natural teeth for the above circumstances includes extraction, amalgam or porcelain restoration, reimplantation, crown, root canal, or

bridge. Implants and care in preparation for implants are not covered

- Injury must have been sustained while eligible for coverage under this Plan or another plan subject to HIPAA as outlined on page 12-13 of this booklet but not greater than two (2) years prior to seeking treatment. Requires Pre-Approval
- A sound natural tooth is one that has not been weakened by existing dental pathology such as decay or periodontal disease, or has not been previously restored by a crown, inlay, onlay, porcelain restoration or treatment by endodontics
- Dental treatment otherwise classified as meeting the exception criteria under Cosmetic and Reconstructive Surgery, above

- 16) **Developmental and Learning Disabilities**: any and all treatment, including services and supplies, for developmental and learning disabilities.
- 17) **Disposable Medical Supplies** including but not limited to medical clothing to block UVA/UVB sun rays, dressing supplies, over-the-counter splints, air casts, corsets, shoe insert orthotics, braces, elastic wraps such as ACE bandages, sanitary items.
- ◆ **Exception**:
 - Gastrointestinal, genitourinary or tracheoesophageal ostomy supplies
 - diabetic supplies required for insulin pump therapy
- 18) **Employment-Related Injury or Sickness** which is covered or eligible for coverage under any workers' compensation or similar law including work hardening programs.
- 19) **Erectile Dysfunction Devices**
- ◆ **Exception**:
 - When needed as a result of disease or surgery.
- 20) **Experimental or Investigational** treatments, procedures, devices, drugs or prescriptions.
- ◆ **Exception**:
 - new technology when written Pre-Approval is obtained by the Participant from the Vermont Managed Care Medical Director
- 21) **Foot Care; Routine** in connection with corns, calluses, or nail care.
- ◆ **Exception**:
 - diabetic foot care

- 22) **Hearing Exams and Hearing Aids** and their fitting or hearing device implants.
- ◆ **Exception:**
 - initial hearing screen as part of preventive evaluation and management
 - Audiology exam
- 23) **Home Birth** charges in connection with home birthing services. Any charges associated with pre-natal care, birthing services or post natal care provided by or submitted for payment by non licensed providers, or a lay midwife.
- 24) **Medical Food:** infant formulas, over-the-counter nutritional supplements.
- ◆ **Exception:**
 - enteral feedings requiring a Provider prescription
 - Medical Foods for inherited metabolic disorders subject to Pre-Approval
- 25) **Mental Retardation:** any and all treatment, including services and supplies, for mental retardation.
- 26) **Non-Medically Necessary Services**
- 27) **Occupational Therapy, Physical Therapy and Speech Therapy** for long term, non-acute medical conditions.
- 28) **Organic Mental Disorders:** any and all treatment, including services and supplies, for Organic Mental Disorders, which, for purposes of the Plan, are any of a group of mental disturbances resulting from temporary or permanent brain dysfunction caused by organic factors such as alcohol, metabolic disorders, and aging.
- 29) **Orthotics**
- ◆ **Exception:**
 - Medically Necessary ankle/foot orthotics (AFO). Subject to Pre-Approval.
 - Diabetics with clinical documentation of pressure areas and/or ulcers of the feet. Subject to Pre-Approval.
- 30) **Outpatient Services** provided in a facility, which are routinely provided in an office setting. Outpatient surgery performed in a non-Network facility located in Addison, Chittenden, Franklin, Grand Isle, Lamoille or Washington counties.

- 31) **Over-the-Counter, Disposable or Consumable Supplies or Convenience Items** including but not limited to devices, AC/DC converters for CPAP, BiPAP, air casts, ace bandage, corsets, home blood pressure monitoring devices, etc.
- ◆ **Exception:** Ostomy supplies
- 32) **Physical Examinations and Medical Care not required for health reasons** including, but not limited to exams, diagnostics and immunizations which are primarily for employment, insurance, government license, court-ordered, forensic, driver or pilot's license, school, athletics, and travel purposes.
- ◆ **Exception:**
 - Provider office visits for recommendations for vaccines required for international travel. Vaccines for travel purposes are excluded.
- 33) **Private Duty Nursing Services**
- ◆ **Exception:**
 - When deemed Medically Necessary by Participating Provider and Pre-Approved by the Plan
- 34) **Private Hospital Rooms**
- ◆ **Exception:**
 - when Medical Necessity is determined by the attending Physician
- 35) **Reversal of Tubal Ligation.**
- 36) **Reversal of Vasectomy.**
- 37) **Services Rendered by Non-Providers:** services rendered by a facility, professional, lay provider or other person or entity that is not licensed to provide services for the treatment of Sickness or Injury.
- 38) **Services paid or eligible for payment by local (e.g. school systems), State or Federal programs except as otherwise required by law.**
- 39) **Services or supplies provided by non-Participating Providers, except as otherwise permitted under this Plan (e.g., Emergency Services, Pre-Approved services).**
- ◆ **Exception:**
 - Out-of-Network benefit coverage
- 40) **Services or supplies that are non Medically Necessary, unless otherwise provided herein.**
- 41) **Smoking Cessation Programs**

- ◆ Exception:
 - prescription medications covered under pharmacy benefit
- 42) **Support Therapies:** e.g. pastoral counseling (except in the case of hospice), assertiveness training, dream therapy, music or art therapy, and recreational therapy.
- 43) **Therapy to Improve General Physical Condition** including, but not limited to weight reduction programs and physical fitness programs.
 - ◆ Exception:
 - cardiac and pulmonary rehabilitation for medical conditions, subject to Pre-Approval
- 44) **Transsexual Surgery and Related Services** including hormone therapy.
- 45) **Travel and Housing Expenses** for Out-of-Network services.
 - ◆ Exception:
 - Subject to Pre-Approval, reasonable travel and housing expenses to the facility may be covered, if Out-of-Network services associated with the travel have been Pre-Approved, for the Participant only and excludes coverage for travel expenses of family members
- 46) **Travel Immunizations.**
- 47) **US Government Owned Facilities** charges for Sickness or Injury connected with military service, past and present, except where such coverage is mandated by law.
- 48) **Vision Care Services** eyeglasses, contacts, magnification vision aids, charges for tinting, anti-reflective coating, prescription sunglasses or light-sensitive lenses, safety glasses or lenses required for employment, or the fitting of such items, radial keratotomy, or any surgery for the purpose of altering, modifying or correcting myopia, hyperopia or stigmatic error, or vision training.
 - ◆ Exception:
 - the treatment of medical eye conditions
 - the first pair of lenses or glasses following cataract surgery, if an intra ocular lens was not surgically implanted
 - Medically Necessary items in connection with Injury to the natural eye, while covered by the Plan
 - one routine eye examination every twenty-four (24) months

- 49) **Whole Blood, Plasma, Cells and Other Blood Derivatives**, if participation in a volunteer blood replacement program is available to you.
- 50) **Wigs or Cranial Prosthesis**
- ◆ Exception:
 - Chemotherapy-induced alopecia only. Requires Pre-Approval.

FILING CLAIMS

In most cases, you will need only to show your Fletcher Allen Preferred Medical Plan identification card to the Provider or Pharmacist who will file your claim for you. After your medical claim has been processed, you will receive a written notice showing what benefits have been paid by the Plan and what charges, if any, remain to be paid by you. This written notice is called an Explanation of Benefits (EOB). No EOB is provided for pharmacy claims.

For some charges, such as those for prescription drugs or medical equipment or other charges billed to you directly, you will need to file a claim yourself. Payment for these charges will be made directly to you unless you specifically request that it be made to the Provider. If you are in doubt as to whether you need to file a claim, ask the Provider that furnished the services. Claim forms are available to download at www.fahcpreferred.org.

Claims must be filed within one-hundred-twenty (120) days of the date the Expense was Incurred. Claims filed after this period will not be honored. Submit claim forms, receipts and itemized bills showing the Plan Participant who received the care or service, the Provider, and the date and type of service received to:

Medical Services

- ◆ Vermont Managed Care
c/o Apex Benefit Services
P.O. Box 3620
Akron, OH 44309-3620

Mental Health and Drug and Alcohol Abuse Services

- ◆ CIGNA Behavioral Health
P. O. Box 188022
Chattanooga, TN 37422

Prescription Drug Services

- ◆ CIGNA Healthcare Prescription Drug Program
P.O. Box 780
Hartford, CT 06142-0780

A separate claim form is required for each member of your family. You may want to keep a copy of all bills and receipts, along with a copy of the completed claim form, for your records. Fletcher Allen Preferred Medical Plan claim forms for Vermont Managed Care, CIGNA Behavioral Health and CIGNA Healthcare Prescription Drug Program are available from Fletcher Allen Health Care, Benefits Department, or by calling the number on the back of your identification card or on the website: www.fahcpreferred.org.

If all or any part of your claim (other than a claim involving Urgent Care) is denied, within thirty (30) days of receipt of your claim the claims administrator will send you an Explanation of Benefits for your claim. In special circumstances, it may take more than thirty (30) days to send an Explanation of Benefits. If an extension is needed, you will receive written notice of the extension before the end of the thirty (30) day period. In no event will the extension be more than fifteen (15) days. If your claim involves Urgent Care, the claims administrator will notify you of the Plan's determination (whether the claim is granted or denied) as soon as possible, taking into account the medical exigencies, but in any case not later than twenty-four (24) hours after receipt of the claim by the Plan. If the claims administrator does not receive all of the information necessary to consider the claim, the claims administrator will notify you of the specific information needed to complete its review. Within twenty-four (24) hours of receipt of the requested information, the claims administrator will notify you of the claims determination.

The Explanation of Benefits will give specific reasons for the denial, reference the specific Plan provisions on which the denial is based, describe any additional material necessary for you to resubmit your claim, explain the Plan's

review procedures, and provide a description of the appeal procedures and applicable time limits. The explanation of benefits will also include a statement of your right to bring a lawsuit under ERISA following an adverse benefit determination on review. If the claims administrator relied on a rule, protocol or guideline in reviewing your claim, it will offer to give you a copy of the applicable rule, protocol or guideline upon request. If the claim was denied based upon a lack of Medical Necessity, or because the treatment was Experimental or Investigational, or other similar exclusion, a statement that an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan is available upon request at no charge.

See the “Appeals Policy” section of this booklet on pages 80-89 for information on how to appeal denied claims.

COORDINATION OF BENEFITS

In many families, especially if both spouses or civil union partners work, family members may be covered by more than one medical plan. Each plan pays benefits, but the plans coordinate their payments so that the total combined payments under both plans are not more than 100% of the Allowable Amount. This is the benefit plan maximum under the Plan. In no circumstances will the benefits payable under this Plan, when added to the benefits paid under the other plan, exceed the amount payable under this Plan. Coordination of Benefits (COB) rules determine the sequence of payments. One plan has primary responsibility and pays first; the other plan has secondary responsibility and pays its benefits for any covered expenses not paid by the primary plan subject to any benefit maximums under the terms of the secondary plan. The following sets forth the order of benefit determination for this Plan when there are multiple benefit plans:

- 1) Non-dependent or dependent. The plan that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree, is primary and the plan that covers the person as a dependent is secondary.
- 2) Child covered under more than one plan. The primary plan is the plan of the parent whose birthday is earlier in the year if the parents are married, the parents are not separated (whether or not they ever have been married), or a court decree awards joint custody without specifying that one parent has the responsibility to provide health care coverage. If both parents have the same birthday, the plan that has covered either of the parents longer is primary. If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage, that plan is primary. If the parent with financial responsibility has no coverage for the child's health care services or expenses, but the parent's spouse or civil union partner does, the spouse's or civil union partner's plan is primary. If the parents are separated (whether or not married) or are divorced, and there is no court decree allocating responsibility for the child's health care services or expenses, the order among the plans is as follows:
 - ◆ The plan of the custodial parent;
 - ◆ The plan of the spouse or civil union partner, if any, of the custodial parent;

- ◆ The plan of the non-custodial parent; and then
 - ◆ The plan of the spouse or civil union partner, if any, of the non-custodial parent.
- 3) Active or inactive Employee. The plan that covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) is primary. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
 - 4) Continuation coverage. If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the plan covering the person as an employee, member, subscriber, or retiree (or as that person's family member) is primary and the continuation coverage is secondary. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
 - 5) Longer or shorter length of coverage. If the preceding rules do not determine the order of benefits, the plan that covered the person for the longer period of time is primary.

Annually, the Plan will request information from each subscriber for all covered family members to determine if there is coverage by multiple Plans. You must complete the Coordination of Benefits (COB) questionnaire mailed to you requesting this information. If you do not respond to the COB questionnaire, your claims payments may be delayed or denied until such time as Vermont Managed Care receives your completed form.

NOTE: *In any event, this Plan will not provide benefits as a secondary plan, such that benefits paid, including benefits paid under the other plan, exceed benefits payable under this Plan. In addition, the Plan will not pay for any item or service for which it would not provide benefits under this Plan in the absence of coverage under the other plan, including but not limited to services not covered because they are provided by a non-Participating Provider.*

SUBROGATION/REIMBURSEMENT

The rules set forth in this section apply to any Sickness or Injury which is:

- ◆ Caused by an act or omission of a third party; or
- ◆ Covered under medical payment provisions of a liability or automobile policy issued to or otherwise covering you or your family member.

If you or your family member receives or is entitled to receive payment from any person, organization or entity in connection with an Injury, Sickness or care for which benefits were provided or will be provided under the Plan, the Plan, or its designee, may recover the amounts it pays or will pay, up to the sum received by you or your family member from or on behalf of the third party.

By you and your family member's participation in the Plan and in consideration for the benefits the Plan provides, you and your family member shall agree to grant the Plan, or its designee, a lien on all funds you or your family member recover up to the total amount of benefits provided by the Plan. The Plan or its designee may give notice of that lien to any party who may have contributed to you or your family member's loss.

By you and your family member's participation in the Plan and in consideration for the benefits the Plan provides, you and your family members agree that the Plan or its designee shall be subrogated to you and your family member's rights to the extent of the benefits provided under the Plan. This includes the Plan's, or its designee's, right to bring suit or file claims against the third party in your or your family member's name.

You and your family members agree to take actions, furnish information and assistance, and execute such instruments as the Plan or its designee may be required to enforce rights under this section. Before the Plan pays any benefits relating to an Injury or Sickness which may have been caused by a third party, it may require you and/or your family member to sign papers confirming the

Plan's right to repayment. You and your family members agree not to take any action which prejudices the Plan's or its designee's rights and interests under this section. If you or your family members do not cooperate in the Plan's or its designee's administration of this section, the Plan will **not** provide coverage for the Sickness or Injury. In addition, you or your family members will be responsible for any legal expenses the Plan or its designee incurs to enforce rights under this section.

The Plan reserves the right to deduct any amounts due the Plan pursuant to this section from future benefit payments for you and your family members.

WHEN COVERAGE ENDS

Your medical coverage will end:

On the earliest date of one of the following events:

- ◆ On the last day of the month in which your employment with Fletcher Allen Health Care ends for any reason;
- ◆ When you no longer qualify as an Employee working 40 hours or more per pay period;
- ◆ If you fail to make the required contribution for medical coverage;
- ◆ When Fletcher Allen Health Care stops offering medical coverage;
- ◆ On the date on which you or a family member falsify information, misrepresent a material fact, utilize fraud or deception for the use of Plan services, or knowingly permit such deception by another person.

Coverage for your family or family member will end:

- ◆ As outlined above, or;
- ◆ At the end of the month when your family member no longer qualifies as an eligible family member (see “Who is Eligible” section in this booklet on pages 10-11 for the definition of eligible family member);
- ◆ If you fail to make the required contribution for family medical coverage;
- ◆ If Fletcher Allen Health Care stops offering family medical coverage.

CONTINUATION OF COVERAGE-CONSOLIDATED OMNIBUS RECONCILIATION ACT (COBRA)

In some cases, you or your covered family members have the option in accordance with federal law (COBRA) to continue coverage beyond the time it would normally end by paying the full cost of continuation coverage. The following sets forth a list of events that may qualify you or your family members to obtain continuation coverage and the duration of continuation coverage you and/or your family members may be able to receive.

If...

Your employment ends for any reason (other than gross misconduct)...

Your hours are reduced and you are no longer a benefits eligible Employee ...

You divorce or legally separate...

You die...

You become entitled to Medicare benefits...

Your covered child no longer qualifies for coverage...

You elect continuation of coverage due to termination of employment, disability or reduction in hours and you or a covered family member are disabled at any time during the first 60 days of continuation coverage (and notify the Plan within 60 days of the actual determination of disability).

Then...

Coverage for you and/or your covered family members can be continued for up to 18 months

Coverage for you and/or your covered family members can be continued for up to 18 months

Coverage for your covered family members can be continued for up to 36 months

Coverage for your covered family members can be continued for up to 36 months

Coverage for your covered family members can be continued for up to 36 months

Coverage for the child can be continued for up to 36 months

Coverage for the disabled person can be continued for an additional 11 months to a total of 29 months.

To be eligible for this continuation coverage, you or your family members must be covered under this Plan on the day before the qualifying event. You can also obtain continuation coverage for children born to, adopted by or placed for adoption with you during your continuation coverage.

You or your family members must notify Fletcher Allen Health Care's Benefits Department within sixty (60) days of your separation or divorce, or when your covered child becomes ineligible for medical coverage, or, if later, within sixty (60) days of the date coverage under the Plan would end for you or your family members. If you or your family members are disabled (as determined under the Social Security Act) at the time of termination or reduction in hours or become disabled at any time during the first sixty (60) days of continuation coverage, you or your family member must notify Fletcher Allen Health Care's Benefits Department within the original eighteen (18) month continuation coverage period and within sixty (60) days after you or your family member receive notification of determination of disability in order for continuation coverage to be extended to twenty-nine (29) months for the disabled person.

After Fletcher Allen Health Care's Benefits Department is informed of such qualifying events or becomes aware of other qualifying events, such as death, termination of employment, reduction in hours or entitlement to Medicare benefits, Fletcher Allen Health Care's Benefits Department will send notification to the third party administrator who will then notify the eligible Participants of the cost and the enrollment process.

Following notification from the Plan's third party administrator of your and/or your family members' eligibility for continuation coverage, in order to obtain such continuation coverage, you and your family members must elect the coverage within sixty (60) days after Plan coverage would otherwise end, or, if later, within sixty (60) days after the date of notice by the Plan's third party

administrator of continuation coverage rights. The failure to elect continuation coverage within this period will result in loss of continuation coverage rights.

You and/or your covered family members must pay the full cost as allowed by law for continuation coverage. Generally, this will be 102% of the cost of providing medical coverage under the Plan (or, in the case of an extension of continuation coverage due to a disability, 150%, provided the disabled individual elects the extension). After notifying the Plan's third party administrator of your intent to continue coverage, you and/or your family will have a forty-five (45) day period in which to pay the costs for the initial month of continuation coverage. Thereafter, costs for continuation coverage must be paid by the date specified by the Plan's third party administrator. Although payments are due on the dates specified by the Plan's third party administrator, you will be given a grace period of thirty (30) days to make each monthly payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. Failure to make the initial or any subsequent payments in accordance with the due dates established by the Plan's third party administrator will result in cancellation of coverage.

If you and a covered family member elect continuation coverage due to termination of employment or reduction in hours, your covered family member may elect an additional continuation period of up to eighteen (18) months (for an overall total of thirty-six (36) months if during the initial continuation period:

- ◆ You divorce
- ◆ You die
- ◆ Your child no longer qualifies for coverage
- ◆ You become eligible for Medicare

To be eligible for the additional continuation coverage, it is your covered family member's responsibility to notify the Plan's third party administrator within

sixty (60) days of the occurrence of one of these events so the third party administrator can be notified in a timely manner.

Continuation coverage under COBRA will end on the earlier of:

- ◆ The date the maximum period of continuation coverage expires
- ◆ The first day for which timely payment of the required cost for continuation coverage is not made
- ◆ The date upon which you or the qualifying family member become entitled to benefits under Medicare, if the Medicare entitlement date is after the date that you or your qualifying family member elected continuation coverage (note, however, that if you become eligible for Medicare, your covered family members may elect an additional continuation period of up to eighteen (18) months, as described above)
- ◆ The date upon which Fletcher Allen Health Care no longer offers medical coverage to its Employees
- ◆ The date upon which you or a family member becomes covered under any other group health plan that does not exclude or limit coverage for a pre-existing condition that you or your family may have
- ◆ In the case of continuation coverage for disability, the first day of the month that begins more than thirty (30) days after a determination that you or your family member are no longer disabled under the Social Security Act.

Please note that you or your family member are responsible for notifying Fletcher Allen Health Care's Benefits Department within thirty (30) days of the date of any final determination that you or your family member are no longer disabled.

No other continuation or conversion of coverage rights apply, except as are specifically set forth under the Plan.

NOTE: *You or your family member may also be eligible to pay for continuation coverage if you or your family member goes on qualified military leave. See page 60 for more information, or you may contact the Fletcher Allen Health Care Benefits Department for more information if this situation applies to you.*

CONTINUATION OF COVERAGE DURING MILITARY LEAVE
(USERRA)

If you are covered by the Plan and enter the United States Armed Forces (including the United States Armed Forces, the Coast Guard, the Army National Guard, the commissioned corps of the Public Health Service, and certain other categories of service), you may be entitled to continue your (and your family members') health coverage under the Plan during your military service for a period of up to twenty-four (24) months. If your military service is thirty (30) days or less, your coverage continues at the same cost as before. As long as the ordinary participant premiums are paid, your coverage continues. If your military service exceeds thirty (30) days, you will need to pay the applicable COBRA premium in order to remain covered.

Even if you do not elect to continue coverage during your military service, you may be entitled to have your coverage reinstated when you return to employment with Fletcher Allen Health Care following honorable discharge, provided that you return to employment within the time periods prescribed by law. No waiting period or exclusion will be imposed in connection with such reinstatement (unless the waiting period or exclusion would have been imposed if you remained covered during your military service) except in the case of Sickness or Injury determined by the Secretary of Veterans' Affairs to be connected with your military service. Separation for uniformed service that is dishonorable or based on bad conduct, on grounds less than honorable, AWOL, or ending in a conviction under court martial would disqualify you from any rights under USERRA.

COORDINATION WITH MEDICARE

Generally, if you continue working at Fletcher Allen Health Care after age 65, the medical coverage provided by Fletcher Allen Health Care will be your primary medical Plan while you continue working. Your spouse or civil union partner, even if age 65 or older, also will have the Plan as primary for his or her benefits. If the Plan is primary, Fletcher Allen Health Care will pay benefits first and Medicare will pay second. The Plan will always pay secondary to Medicare for you and your family members in those instances where Medicare is the primary payor under applicable Federal law.

DEFINITIONS

- 1) **Acute**
A sudden or abrupt change in your health status that requires treatment expected to produce improvement within a reasonable and predictable period of time.

- 2) **Alcohol and Drug Abuse**
Conditions related to the excessive use or misuse of alcohol or drugs leading to a dependence or the use of drugs (including alcohol) for non-therapeutic effect especially one for which it was not prescribed or intended with the potential for physical, social or psychological harm. Conditions as listed in the Mental Disorders Section in the International Classification of Diseases Manual (ICD-9-CM) as follows:
 - a. Alcohol and drug psychosis
 - b. Alcohol dependence syndromes
 - c. Drug dependence
 - d. Non-dependent abuse of drugs, except tobacco use disorder and other, mixed or unspecified drug abuse

- 3) **Allowed Amount**
The maximum allowable reimbursement amount determined to be payable by the Plan to Participating Providers under the Participating Provider's contract to provide covered services to Participants.

With respect to a non-Participating Provider, the Allowed Amount means the Reasonable and Customary Charge.

- 4) **Benefit Maximum**
The limit placed on Plan payments for certain procedures or services. A Benefit Maximum can:
 - a. Apply to specific benefit categories or to all benefits;
 - b. Apply to a specific time period, such as annual or lifetime; whenever the term "lifetime benefit maximum" appears, it refers to the time you or your family members are covered under the Plan.

- 5) **Charges**
The actual billed charges; except when the Participating Provider has contracted directly or indirectly with the Plan for a different amount.

- 6) **Chronic Care**
Care that is not likely to produce measurable improvement in a reasonable and predictable length of time.

- 7) **Civil Union Partner**
A relationship established between two persons of the same sex pursuant to 15 V.S.A. Chapter 23 that entitles the parties to the benefits and protections of spouses or civil union partners and subjects them to the responsibilities of spouses or civil union partners.
- 8) **Claim Involving Urgent Care**
Any claim for medical care or treatment with respect to which the application of the time periods for Pre-Approval of services
- a. Could seriously jeopardize your life or health or your ability to regain maximum function, or
 - b. In the opinion of your Provider, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.
- 9) **Coinsurance**
The percentage of the Allowed Amount for your covered services that you pay.
- 10) **Copayment**
The predetermined fee that you pay directly to the Participating Provider when you receive services.
- 11) **Custodial Services**
Any services which are not intended primarily to treat a specific Injury or Sickness (including mental illness, alcohol or drug abuse). Custodial Services include, but shall not be limited to:
- a. Services related to watching or protecting a Participant;
 - b. Services related to performing or assisting a Participant in performing any activities of daily living, such as:
 - walking
 - grooming
 - bathing
 - dressing
 - getting in or out of bed
 - toileting
 - eating
 - preparing foods; or
 - taking medications that usually would be self-administered; and
 - c. Services not required to be performed by trained or skilled medical or paramedical personnel.

12) **Deductible**

The amount of expenses for covered services that a Participant must pay before the Plan will begin its payments for covered services.

If two or more family members receive accidental bodily injuries in a single accident, only one deductible amount shall be required for all medical expenses and charges related to the treatment of such accidental Injuries.

13) **Durable Medical Equipment**

Equipment which is prescribed by a Provider and:

- a. Is primarily and customarily used to serve a medical purpose;
- b. Is generally not useful to a Participant in the absence of Sickness or Injury;
- c. Is appropriate for use in the home; and
- d. Can withstand repeated use.

14) **Emergency Services**

Medical, surgical, or Mental Health Hospital and related health care services, including ambulance service, required for the alleviation of severe pain or to treat an Injury or a sudden, unexpected onset of a serious Sickness which a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious medical complications, loss of life, permanent impairment of bodily functions, or serious dysfunction of a body organ or part, as determined by the Plan in accordance with generally accepted medical standards.

15) **Employee**

A full-time employee of Fletcher Allen Health Care who is currently in active service and who normally works between 72 to 80 hours per pay period. It also includes a part-time Employee of Fletcher Allen Health Care who is currently in active service and who normally works between 40 to 71 hours per pay period. The term does not include employees who are classified as Per Diem or Regularly Scheduled Special (RSS).

16) **Employer**

Fletcher Allen Health Care and all affiliated employers.

17) **Expense Incurred**

An expense is incurred when the service or the product is provided to the Participant.

18) **Experimental/Investigative**

A drug, device, medical treatment or procedure that is determined by the Plan to meet one or more of the following criteria in relation to the condition for which it is being dispensed or rendered:

- a. The drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and approval for marketing has not been given at the time the drug or device is furnished; or
- b. Reliable evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials may be necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.
- c. Reliable evidence includes, but is not limited to, published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment or procedure; or written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

19) **Home Health Aide**

A person who:

- a. Provides care of a medical or therapeutic nature; and
- b. Reports to and is under the direct supervision of a Home Health Care Agency

20) **Home Health Care Agency**

An organization - public, non-profit or for-profit - that provides in-home nursing or other health care services for a fee which:

- a. Primarily provides skilled nursing service and other therapeutic service under the supervision of a Provider or a Registered Nurse;
- b. Is run according to regulatory rules and regulations established by a group of professional persons, e.g. The Joint Commission;
- c. Maintains clinical records on all patients;
- d. Does not primarily provide custodial care; and
- e. Fulfills any licensing requirements of the state or locality in which it operates.

21) **Hospice Facility**

An institution or part of it which:

- a. Primarily provides care for terminally ill patients;

- b. Is accredited by the National Hospice Organization;
- c. Fulfills any licensing requirements of the state or locality in which it operates.

22) **Hospital**

- a. An institution licensed as a hospital, which:
 - maintains, on the premises, all facilities necessary for medical and surgical treatment for which the hospital is licensed;
 - provides such treatment on an inpatient basis, for compensation, under the supervision of Physicians;
 - provides 24-hour service by Registered Nurses; and
 - Maintains daily clinical records on each patient and has available at all times the services of a Physician under an established agreement;
- b. Other institutions including: rehabilitative Hospital, Hospice Facility, or ambulatory surgical care center which operates primarily to provide elective surgical care and admits and discharges each patient within a working day.

23) **Hospital Confinement**

A Participant will be considered confined in a Hospital if s/he is a registered bed patient in a Hospital upon the recommendation of a Provider.

24) **Injury**

An accidental act that harms or damages.

25) **Medicaid**

The state program of medical aid for needy persons established under Title XIX of the Social Security Act of 1965 as amended.

26) **Medical Director**

A Physician who is employed by or contracted to conduct utilization review determinations for Vermont Managed Care. The Medical Director has overall authority for the Utilization Management Plan and the Provider Credentials Plan.

27) **Medically Necessary Care**

Services or supplies received from a qualified Provider that are required to identify or treat a Sickness or Injury. These services or supplies must be directed and supervised by a Provider, consistent with the symptom or diagnosis and medical practice, and be the most appropriate supply or level of service with regard to a Participant's safety. Service or supplies that are solely for the convenience of a Participant or a Provider are not considered Medically Necessary when specifically applied to an inpatient stay. Medically Necessary inpatient care also means that the Participant's

condition could not be treated safely on an outpatient basis or alternative treatment setting.

28) **Medicare**

The program of medical care benefits provided under Title XVIII of the Social Security Act of 1965 as amended.

29) **Mental Health and Substance Abuse Treatment**

- a. Mental Health Treatment: A branch of medicine that deals with the achievement and maintenance of psychological well being.
- b. Substance Abuse Treatment: Treatment for the over indulgence in and/or dependence on an addictive substance, especially alcohol or a narcotic drug. Also called *chemical abuse* or *Alcohol and Drug Abuse*.
- c. Partial Hospitalization Program (PHP): six (6) hours of individual care management, group psychotherapy, pharmacological management, and coping skills training for individuals who are transitioning from inpatient care back to the community, or hospital diversion for individuals who are experiencing worsening symptoms. Primary purpose is to stabilize functioning, and restore symptoms to a pre-crisis level.
- d. Intensive Outpatient Program (IOP): three (3) hours per day of group psychotherapy, coping skills training, and medication consultation with a lesser degree of care management for individuals who are already working in individual therapy in the community, but are experiencing an increase in symptom severity such that standard outpatient treatment alone is not sufficient to make progress. The primary purpose is to assist in coping skills acquisition and coping skills usage in daily life.

30) **Mental Illness**

Any disorder, other than organic mental disorders, mental retardation, developmental and learning disabilities or a disorder induced by alcohol or drug abuse, which impairs the behavior, emotional reaction or thought process of a person, regardless of medical origin. In determining benefits payable, charges made for the treatment of any physiological symptoms related to a mental illness will not be considered to be charges made for treatment of a mental illness.

31) **Network**

The Physicians, pharmacies, Hospitals and other health care Providers who have agreed to provide covered services to Participants.

The Vermont Managed Care Network is the panel of medical services providers listed on the Fletcher Allen Preferred Medical Plan website (www.fahcpreferred.org) or in the printed Vermont Managed Care Provider Directory.

The CIGNA Healthcare Prescription Drug Program Network of participating pharmacies can be found on the CIGNA website (www.CIGNA.com).

The CIGNA Behavioral Healthcare Network information can be obtained on the CBH website (www.cignabehavioral.com) or by calling 1-800-554-6931.

32) **Nurse**

A Registered Professional Nurse, Registered Graduate Nurse, a Licensed Practical Nurse or a Licensed Vocational Nurse who has the right to use the abbreviation “R.N.,” “L.P.N.,” or “L.V.N.”

33) **Out-of-Network**

Providers or services that are not participating with Vermont Managed Care, CIGNA Behavioral Health Care or CIGNA Healthcare Prescription Drug Program.

34) **Out-of-Pocket Maximum**

The total amount of Coinsurance and Deductible expenses for covered services that the Participant is subject to each calendar year for those particular services to which the Out-of-Pocket Maximum applies.

- a. The individual out-of-pocket maximum applies separately to each Participant;
- b. The family out-of-pocket maximum applies collectively to all covered Participants in the same family. When the family out-of-pocket maximum is reached, the Plan will pay 100% of specific covered services for all covered family members during the remainder of the calendar year, subject to Plan maximums.
- c. This Plan has separate Out-of-Pocket Maximum terms for In-Network and Out-of-Network coverage benefits.

The Out-of-Pocket Maximum excludes Copayments and amounts paid in excess of Benefit Maximums. Coinsurance and Deductible amounts paid by you are included.

35) **Participant**

Employees and family members who meet the Plan’s eligibility requirements, or who are eligible for continuation coverage under COBRA or the Uniformed Services Employment and Reemployment Rights Act (USERRA), and who have elected coverage under the Plan.

36) **Participating Provider**

A Provider that has contracted with the Plan or on whose behalf a contract has been entered into with the Plan to provide covered services to Participants.

Participating Provider contracts may include incentives to deliver services in a cost-effective manner. The Participating Providers may change from time to time. A list of the current Vermont Managed Care Network Participating Providers is available at www.fahcpreferred.org.

The CIGNA Healthcare Prescription Drug Program Network of participating pharmacies can be found on the CIGNA web-site (www.CIGNA.com).

The CIGNA Behavioral Healthcare Network information can be found on the CBH website (www.cignabehavioral.com) or can be obtained by calling 1-800-554-6931.

37) **Pharmacist**

A specialist in formulating and dispensing medications. Pharmacists are licensed by the various States to practice pharmacology.

38) **Physician**

A licensed medical practitioner (other than Nurse Practitioner) who has completed the education necessary and holds the degree of MD, DO or a graduate of a foreign education program recognized by Vermont Managed Care to qualify as a physician who is practicing within the scope of his/her license and who is licensed to prescribe and administer drugs or to perform surgery. It also includes any other licensed medical practitioner whose services are required to be covered by law in the locality where the policy is issued if s/he is:

- a. Operating within the scope of his/her license; and
- b. Performing a service for which benefits are provided under this Plan when performed by a Physician.

39) **Plan**

The Fletcher Allen Preferred Plus Medical Plan.

40) **Plan Year**

January 1 - December 31

41) **Pre-Approval**

The process in which proposed medical services are reviewed by the Vermont Managed Care, Care Management department and a determination is made regarding the Medical Necessity of the proposed service.

42) **Prescription Drug**

- a. A drug which has been approved by the Food and Drug Administration for safety and efficacy; or
- b. Certain drugs approved under the Drug Efficacy Study Implementation review; or
- c. Drugs marketed prior to 1938 and not subject to review, and which can, under federal or state law, be dispensed only pursuant to a prescription order; or
- d. Injectable insulin.

43) **Preventive Care**

A pattern of health care that focuses on the prevention of disease and health maintenance and includes early diagnosis of disease, discovery and identification of people at risk of developing specific problems, counseling and other interventions to avert a health problem. Screening tests, health education and immunization programs are common examples of preventive care. The specific services included in preventive care are determined by the Plan.

44) **Primary Care Physician (PCP)**

A Physician:

- a. Who qualifies as a Participating Provider in general practice, internal medicine, family practice or pediatrics; and
- b. Who has been selected by you, as authorized by Vermont Managed Care, to provide or arrange for medical care for you or any of your covered family members.

45) **Provider**

A facility, professional or other provider that is qualified through education, training and is licensed to provide services for the treatment of Sickness or Injury, where required, and is acting within the scope of their license issued by the state in which they practice.

46) **Psychiatrist**

Physicians who have a specialty in Psychiatry or Addiction Medicine. In addition to diagnosing problems and treating patients through talk therapy, a Psychiatrist can prescribe medication for your behavioral health problems if necessary. Many psychiatrists also have subspecialties such as: Children and Adolescents; Geriatric; Addiction Medicine, etc.

47) **Psychologists and Masters level therapists**

These are therapists-psychologists with advanced degrees, such as Masters (MS) or Doctorate (PhD.), Licensed Psychologist (i.e., LP), family

therapists (i.e., LMFT, LMC), social workers (i.e., LCSW, LSW), nurse practitioners (i.e., ARNP, APRN), and clinicians (i.e., LMHC) who primarily use talk therapy to help you assess the difficulty you are experiencing and identify solutions. All therapists must be licensed or certified as required by the State in which they practice.

48) **Reasonable and Customary Charge**

A charge will be considered Reasonable and Customary if:

- a. It is the normal charge made by the Provider for a similar service or supply; and
- b. It does not exceed the normal charge made by most Providers of such service or supply in the geographic area where the service is received, as determined by the Plan.

To determine if a charge is Reasonable and Customary, the nature and severity of the Injury or Sickness being treated will be considered.

With respect to a Participating Provider, the Reasonable and Customary Charge means the Allowed Amount.

49) **Room and Board**

All charges made by a Hospital on its own behalf for room and meals and for all general services and activities needed for the care of registered bed patients.

50) **Sickness**

A physical illness or Mental Illness. It also includes pregnancy. Expenses incurred for routine Hospital and pediatric care of a newborn child prior to discharge from the Hospital nursery will be considered to be incurred as a result of Sickness.

51) **Skilled Nursing Facility (SNF)**

A licensed institution (other than a Hospital, as defined) which specializes in:

- a. Physical rehabilitation on an inpatient basis; or
- b. Skilled nursing and medical care on an inpatient basis;

But only if that institution:

- maintains on the premises all facilities necessary for medical treatment;
- provides such treatment, for compensation, under the supervision of Physicians; and
- provides Nursing services 24 hours per day.

52) **Terminal Illness**

An illness will be considered a Terminal Illness if a person becomes ill with a prognosis of six months or less to live, as diagnosed by a Provider.

53) **Urgent Care**

Medical Care or treatment that must be provided within forty-eight (48) hours to:

- a. Preserve your life, health, or ability to regain maximum function, or
- b. Treat severe pain that cannot be adequately managed without the care or treatment.

ERISA RIGHTS

As a Participant in the Fletcher Allen Preferred Medical Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the Plan and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

You are entitled to continue health care coverage for yourself, your spouse or civil union partner or your family members if there is a loss of coverage under the Plan as a result of a qualifying event. You or your family members may

have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

You are entitled to a reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your Employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

PLAN INFORMATION

Name of Plan

- ◆ Fletcher Allen Preferred Medical Plan

Plan Sponsor

- ◆ Fletcher Allen Health Care, Inc.
111 Colchester Avenue
Burlington, VT 05401
(802) 847-2825

Employer Identification Number

- ◆ 03-0219309

Plan Number

- ◆ 862

Type of Plan

- ◆ Group Health Plan

Type of Administration

- ◆ The Plan is administered by the Plan Sponsor, which has contracted with claims administrators to process claims, contract with Participating Providers and to perform other administrative functions.

Type of Funding

- ◆ The Plan is funded by Fletcher Allen Health Care through Employer and Employee contributions.

Plan Administrator

- ◆ Fletcher Allen Health Care, Inc.
111 Colchester Avenue
Burlington, VT 05401
(802) 847-2825

To the extent permitted by applicable law, the Plan Administrator has the responsibility and authority to apply and interpret the Plan at its sole discretion.

Claims Administrators

- ◆ Vermont Managed Care, Inc.
C/O Apex Benefit Services (*medical services*)
P.O. Box 3620
Akron, OH 44309-3620
- ◆ CIGNA Behavioral Health (*mental health and substance abuse*)
P.O. Box 188022
Chattanooga, TN 37422
(800) 926-2273
- ◆ CIGNA Healthcare Prescription Drug Program (*prescription drugs*)
P.O. Box 780
Hartford, CT 06142-0780
(800) 622-5579

Agent for Service of Legal Process

- ◆ Manager of Benefits
Fletcher Allen Health Care
111 Colchester Avenue
Burlington, VT 05401
(802) 847-2825

Service of legal process may also be made on the Plan Administrator.

Plan Year

- ◆ January 1 to December 31

Amendment or Termination

While Fletcher Allen Health Care expects to continue the coverage described in this booklet indefinitely, it reserves the right to amend or terminate this coverage at any time, for any reason, to the extent permitted by law.

APPEALS POLICY

Vermont Managed Care, Inc., an affiliate of Fletcher Allen Health Care, administers a process for Fletcher Allen Preferred Medical Plan Participants to appeal denials of medical coverage decisions. CIGNA Behavioral Health administers a process for Fletcher Allen Preferred Medical Plan Participants to appeal denials of Mental Health and Drug and Alcohol Abuse coverage decisions. Except where specified below (under “Mental Health/Drug and Alcohol Abuse Appeals”), this appeals policy applies for both medical coverage and Mental Health/Drug and Alcohol Abuse appeals, and any reference below to “Vermont Managed Care” should be read as “CIGNA Behavioral Health” where the appeal involves Mental Health and/or Drug and Alcohol Abuse appeals.

The purpose of this process, by which you or your family member or your or your family member’s authorized representative (collectively referred to as you or your throughout this section), is for you to appeal denial of requests for Pre-Approval of services, reduction or termination of concurrent care, or claim denials made by Vermont Managed Care. An Employee Participant may appeal denial of requests for Pre-Approval of services, reduction or termination of concurrent care, or claim denials made by Vermont Managed Care for his/her own claims and services, and his/her family members’ claims and services. A family member may also appeal denial of requests for Pre-Approval of services, reduction or termination of concurrent care, or claim denials made by Vermont Managed Care for his/her own claims. Vermont Managed Care will only review one person’s appeal for each denial of request for Pre-Approval of services, reduction or termination of concurrent care, or claim denials made by Vermont Managed Care. For example, if the Employee appeals a denial and the family member later appeals the same denial, Vermont Managed Care will only address

the first appeal and will reject the appeal by the family member as a duplicate appeal.

A family member may terminate the Employee's authority to appeal denial of requests for Pre-Approval of services, reduction or termination of concurrent care, or claim denials made by Vermont Managed Care for the family member pursuant to this section by notifying Vermont Managed Care in writing of such termination.

Because the appeals process varies depending on the type of denial, the policy is divided into four sections: denial of requests for Pre-Approval of Claims Involving Urgent Care, denial of requests for Pre-Approval of all other claims, reduction or termination of concurrent care claims, and denial of claims for which services have already been provided.

All decisions on appeal will be in writing and will include the following information: the specific reason(s) for the determination; reference to the specific Plan provision(s) on which the determination is based; a statement that you are entitled to receive reasonable access to and copies of all documents, records and other information relevant to your claim, upon request and free of charge; a statement of your right to bring a lawsuit under ERISA Section 502(a) following an adverse benefit determination on review; if an internal rule, guideline or protocol was relied upon, a statement that the rule, guideline or protocol is available upon request at no charge; if the determination was based on a lack of Medical Necessity, or because the treatment was Experimental or Investigational, or other similar exclusion, an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to your claim. If your final appeal is ultimately denied in whole or in part, you have the right to file a lawsuit under the Employee Retirement Income Security Act of 1974 (ERISA).

Denial of Requests for Pre-Approval of Claims Involving Urgent Care**◆ *First Appeal***

Upon receipt of written or verbal notice from Vermont Managed Care of a denial (in whole or in part) of a request for Pre-Approval of a Claim Involving Urgent Care, you may submit a request (verbal or written) appealing the denial. Be sure to state why you believe the claim should not have been denied, a description of the medical circumstances that exist which require review as a Claim Involving Urgent Care, and submit any data, questions or comments you think appropriate. Upon your request and free of charge, you may have reasonable access to, and copies of, all documents, records, and other information the Claims Administrator has relating to your request for Pre-Approval of a Claim Involving Urgent Care. Your appeal will be reviewed by Vermont Managed Care. If Vermont Managed Care determines that your claim is not a Claim Involving Urgent Care, your appeal will be handled in accordance with the procedures for denial of requests for Pre-Approval of all other claims, or denial of claims for services which have already been provided (both set forth below), whichever is applicable.

A decision on the first appeal of a Claim Involving Urgent Care will be made by Vermont Managed Care within 72 hours after receipt of your request for review.

Vermont Managed Care may notify you verbally of its decision and will also send its decision in writing. If the appeal is denied, the written notice will include the specific reasons for the decision, specific references to the appropriate Plan provisions on which the decision is based, and your right to appeal the denial.

◆ *Second Appeal*

Upon receipt of written or verbal notice from Vermont Managed Care of a denial (in whole or in part) of your first appeal of a denial for request for Pre-Approval of a Claim Involving Urgent Care, you may submit a request (verbal or written) appealing the denial. Be sure to state why you believe the claim should not have been denied, a description of the medical circumstances that still exist which require review as a Claim Involving Urgent Care, and submit any data, questions or comments you think appropriate. Upon your request and free of charge, you may have reasonable access to, and copies of, all documents, records, and other information the Claims Administrator has relating to your request for Pre-Approval of a Claim Involving Urgent Care, and your first appeal. Your appeal will be reviewed by members of Vermont Managed Care's Care Management Committee. The Care Management Committee is a committee

of Vermont Managed Care's Board of Directors, and is comprised of Physicians and Vermont Managed Care staff members. Medical Necessity appeals will be reviewed and a decision will be made by Physicians, none of whom will have been involved in the original denial of your claim or review of your first appeal. Contractual/Benefit Limitation appeals will be reviewed and a decision will be made by Vermont Managed Care employee staff, designated by the Care Management Committee, none of whom will have been involved in the original denial of your claim or review of your first appeal.

If Vermont Managed Care determines that your second appeal does not relate to a Claim Involving Urgent Care, your appeal will be handled in accordance with the procedures for denial of requests for Pre-Approval of all other claims, or denial of claims for services which have already been provided (both set forth below), whichever is applicable.

A decision on the second appeal of a denial of a Claim Involving Urgent Care will be made by Vermont Managed Care within 72 hours after receipt of your request for review.

Vermont Managed Care may notify you verbally of its decision and will also send its decision in writing. If the appeal is denied, the written notice will include the specific reasons for the decision as well as specific references to the appropriate Plan provisions on which the decision is based. The notice will also include any further legal rights you may have with respect to the denied appeal, including any right to bring a civil action under federal law.

The decision of the Vermont Managed Care, Care Management Committee at the second level is final.

Denial of Requests for Pre-Approval of Claims Other than Claims Involving Urgent Care

◆ ***First Appeal***

Upon receipt of written notice from Vermont Managed Care of a denial (in whole or in part) of a request for Pre-Approval of a claim, you may submit a written request appealing the denial. Be sure to state why you believe the claim should not have been denied, and submit any data, questions or comments you think appropriate. Upon your request and free of charge, you may have reasonable access to, and copies of, all documents, records, and other information the Claims Administrator has relating to your request for Pre-Approval of a claim. Your appeal will be reviewed by Vermont Managed Care.

A decision on the first appeal will be made by Vermont Managed Care within 30 days after receipt of your request for review.

Vermont Managed Care will send written notice of its decision. If the appeal is denied, the written notice will include the specific reasons for the decision, specific references to the appropriate Plan provisions on which the decision is based, and your right to appeal the denial.

◆ ***Second Appeal***

Upon receipt of written notice from Vermont Managed Care of a denial (in whole or in part) of your first appeal of a denial for request for Pre-Approval of a Claim other than a Claim Involving Urgent Care, you may submit a written request appealing the denial. Be sure to state why you believe the claim should not have been denied, and submit any data, questions or comments you think appropriate. Upon your request and free of charge, you may have reasonable access to, and copies of, all documents, records, and other information the Claims Administrator has relating to your claim and first appeal. Your appeal will be reviewed by members of Vermont Managed Care's Care Management Committee. The Care Management Committee is a committee of Vermont Managed Care's Board of Directors, and is comprised of Physicians and Vermont Managed Care staff members. Medical Necessity appeals will be reviewed and a decision will be made by Physicians, none of whom will have been involved in the original denial of your claim or review of your first appeal. Contractual/Benefit Limitation appeals will be reviewed and a decision will be made by Vermont Managed Care employee staff, designated by the Care Management Committee, none of whom will have been involved in the original denial of your claim or review of your first appeal. Your appeal will be reviewed at a meeting of committee members and you may participate in the meeting to provide information in support of your second appeal. The committee members will then make a decision on your appeal.

Vermont Managed Care will notify you of its decision with a written decision on your second appeal within 30 days after receipt of your request for review. If the appeal is denied, the written notice will include the specific reasons for the decision as well as specific references to the appropriate Plan provisions on which the decision is based. The notice will also include any further legal rights you may have with respect to the denied appeal, including any right to bring a civil action under federal law.

The decision of the Vermont Managed Care, Care Management Committee at the second level is final.

Denial of Claims for Concurrent Care

If Vermont Managed Care has approved an ongoing course of treatment to be provided over a period of time or for a certain number of times and Vermont Managed Care reduces or terminates care authorized as part of the ongoing course of treatment, Vermont Managed Care will notify you sufficiently in advance of such reduction or termination to reasonably allow an appeal and determination by Vermont Managed Care on your appeal. The written notice will give specific reasons for the reduction or termination, reference the specific Plan provision on which the reduction or termination is based, describe any additional material necessary for you to resubmit your claim, and explain the Plan's review procedures. If Vermont Managed Care relied on its rules, protocols or guidelines in reviewing your claim, it will give you a copy of the applicable rule, protocol or guideline free of charge upon request.

You or your authorized representative may submit a request appealing the reduction or termination. You must appeal the reduction or termination of services within a reasonable time after receiving notice. Be sure to state why you believe the claim should not have been denied, and submit any data, questions or comments you think are appropriate. Upon your request and free of charge, you may have reasonable access to, and copies of, all documents, records, and other information Vermont Managed Care has relating to the reduction or termination. Your appeal will be reviewed by Vermont Managed Care.

If the appeal of the reduction or termination of concurrent care qualifies as a Claim Involving Urgent Care it will be handled in accordance with the policy set forth in this section above. Otherwise, appeals of reductions or terminations of concurrent care will be handled in accordance with the policies set forth in this section for denial of requests for Pre-Approval of a claim other than Claims Involving Urgent Care, or denial of a claim for services already provided, whichever is applicable.

Denial of Claims for which Services Have Already Been Provided**◆ *First Appeal***

Within 180 days of receiving written notice of a claim denial (in whole or in part), you or your authorized representative may submit a written request appealing the claim denial. Be sure to state why you believe the claim should not have been denied, and submit any data, questions or comments you think are appropriate. Upon your request and free of charge, you may have reasonable access to, and copies of, all documents, records, and other information the Claims Administrator has relating to your claim. Your appeal will be reviewed by Vermont Managed Care.

A decision on the first appeal will be made by Vermont Managed Care within 60 days after the receipt of your request for review.

The decision on the review will be in writing and will include the specific reasons for the decision, specific references to the appropriate Plan provisions on which the decision is based, and your right to appeal the denial. The notice will also include any further legal rights you may have with respect to the denied appeal, including any right to bring a civil action under federal law.

Imposition of any Copayment requirements by a Participating Provider at the time of the service, and pursuant to the Participating Provider's Network contract and this Plan, is not a denial of request for Pre-Approval of services, reduction or termination of concurrent care, or claim denial made by Vermont Managed Care and is not subject to the appeals process described in this section.

◆ ***Second Appeal***

Upon receipt of written notice from Vermont Managed Care of a denial (in whole or in part) of your first appeal of the claim denial, you may submit a written request appealing the denial. Be sure to state why you believe the claim should not have been denied, and submit any data, questions or comments you think appropriate. Upon your request and free of charge, you may have reasonable access to, and copies of, all documents, records, and other information the claims administrator has relating to your claim and first appeal. Your appeal will be reviewed by the Vermont Managed Care, Care Management Committee. The Care Management Committee is a committee of Vermont Managed Care's Board of Directors, and is comprised of Physicians and Vermont Managed Care staff members. Medical Necessity appeals will be reviewed and a decision will be made by Physicians, none of whom will have been involved in the original denial of your claim or review of your first appeal. Contractual/Benefit Limitation appeals will be reviewed and a decision will be made by Vermont Managed Care employee staff, designated by the Care Management Committee, none of whom will have been involved in the original denial of your claim or review of your first appeal. Your appeal will be reviewed at a meeting of committee members and you may participate in the meeting to provide information in support of your second appeal. The committee members will then make a decision on your appeal.

Vermont Managed Care will notify you of its decision with a written decision on your second appeal within 30 days after receipt of your request for review. If the appeal is denied, the written notice will include the specific reasons for the decision as well as specific references to the

appropriate Plan provisions on which the decision is based. The notice will also include any further legal rights you may have with respect to the denied appeal, including any right to bring a civil action under federal law.

The decision of the Vermont Managed Care, Care Management Committee at the second level is final.

Mental Health/Drug and Alcohol Abuse Appeals

The CIGNA Behavioral Health (CBH) appeals process follows the standards of the American Accreditation Healthcare Commission (AAHCC – formerly URAC) and National Committee on Quality Assurance (NCQA). Participants are encouraged, but not required, to take advantage of the following voluntary initial review process prior to formally initiating their appeal. Also included below is a description of how CBH administers the First and Second Appeals discussed above.

Voluntary Reviews

Step 1

Call CIGNA Behavioral Health at 1-800-554-6931 and speak to a representative if you have a complaint or question about the following:

- Denial of mental health or substance abuse treatment claims
- Denial of mental health or substance abuse services
- Quality of care with CBH Participating Providers

If CBH can resolve your question or complaint at the time of your call, no further action will be taken by CBH. Should CBH not be able to resolve your complaint or question to your satisfaction, you have the option to request an appeal.

Whenever you take a step in the appeal process outlined in Step 2-4, CBH will send you a letter acknowledging your appeal request and containing instructions for the next step. Be sure to retain this letter for your reference.

Response Time Frame for an Appeal:

Varies according to level of appeal. See the following steps.

Step 2

Peer-to-Peer Review: Initial Determination.

If you or your provider are not satisfied with the initial determination of the Clinical Review process with the CBH Care Manager – the process that determines benefit payment based on a combination of your provider's recommendation and CIGNA's Behavioral Health's level of care guidelines –

either of you may contact the Care Manager (an employee of CIGNA holding a degree in psychology, human services or a related field who acts as a consultant for your provider). He or she will organize a peer-to-peer review, in which your case will be discussed between your provider and another clinician who has the same or similar licensure.

If this does not resolve your concern, CBH will (when appropriate), contact you or your provider, offering an expedited 1st level appeal by phone. If an expedited appeal is not appropriate, a standard 1st level appeal will be offered. You or your provider can request a standard 1st level appeal within no more than 365 days of the determination.

Response Time Frame:

- Inpatient peer-to-peer reviews will be scheduled within 24 hours.
- Outpatient peer-to-peer reviews will be scheduled within 15 calendar days.

Appeals

First Appeal

In this process, another clinician holding the same licensure as your Provider will independently review your case. If the determination for benefit payment is not satisfactory to you, CBH will communicate in writing with you, or your provider (whoever has requested the appeal), providing instructions for initiating a second appeal. You are responsible for the release of your medical records in order for this process to take place.

At the end of each level of appeal, a written notification of the final outcome and resolution, including the clinical explanation for benefit determination, will be sent to you, your Provider, or facility.

Second Appeal

CIGNA Behavioral Health's Formal Appeals Committee reviews all second appeals *with your approval or written request*. The Committee reviews for Medical Necessity and coverage under your benefit plan. This committee is comprised of medical management (CBH MD), two lay people (CBH employees from different departments: ie claims, advocacy) and your appeals coordinator – a CBH employee who assures that you have access to all your legal rights of appeal. At this level of appeal, you, your Provider or anyone you delegate has the right to participate by phone in the review process.

Prescription Drug Appeals

Denial of Claims for CIGNA Healthcare Prescription Drug Program

If you feel your prescription drug claim deserves further consideration, you may appeal this decision. Be sure to include additional information which will support your request. This will assist CIGNA Healthcare Prescription Drug Program in the review of the claim. You may appeal in writing to:

- ◆ CIGNA Healthcare Prescription Drug Program
Attn: Appeals
P.O. Box 780
Hartford, CT 06142-0780

Fletcher Allen Health Care Medical Plans Privacy Notice

A federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), requires that health plans protect the confidentiality of your private health information.

Under HIPAA, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Plan or with the Secretary of the U.S. Department of the Health and Human Services if you believe your rights under HIPAA have been violated.

This Plan maintains a privacy notice, which provides a complete description of your rights under HIPAA. This notice is distributed to you annually. For a copy of the notice, please contact Barbara Drapola, Privacy Officer, Vermont Managed Care, (802) 847-8161.

If you wish to file a request to the health plan to not use or disclose health information, or if you wish to file a complaint with the Plan regarding your protected health information, you may do so by contacting Barbara Drapola, Privacy Officer, Vermont Managed Care, (802) 847-8161.

Disclosure of Information to the Plan Sponsor

This Plan, and the Plan Sponsor, will not use or further disclose information that is protected by HIPAA (“protected health information”) except as necessary for treatment, payment, health plan operations and Plan administration, or as permitted or required by law. By law, the Plan has required all of its Plan Sponsors to also observe HIPAA’s privacy rules.

The Plan may provide summary health information to the Plan Sponsor so that the Plan Sponsor may solicit premium bids from health insurers or modify, amend or terminate the Plan. The Plan also may disclose to the Plan Sponsor information on whether you are participating in the Plan, or are enrolled in or have disenrolled from a health insurance issuer or HMO offered by the Plan.

In addition, the Plan may disclose your protected health information to the Plan Sponsor as necessary for the Plan Sponsor to perform administration functions on behalf of the Plan. The Plan may not disclose protected health information to the Plan Sponsor for the purpose of employment-related actions or decisions or

in connection with any other benefit or employee benefit plan of the Plan Sponsor.

The Plan will disclose protected health information to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor that the Plan Sponsor agrees to:

- ◆ Not use or further disclose the information other than as permitted or required by the Plan documents or as required by law;
- ◆ Ensure that any agents to whom it provides protected health information received from the Plan agree to the same restrictions that apply to the Plan Sponsor with respect to such information;
- ◆ Not use or disclose the information for employment related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;
- ◆ Report to the Plan any use or disclosure of protected health information that is inconsistent with the uses or disclosures provided for of which it becomes aware;
- ◆ Make protected health information about an individual available to that individual, in accordance with the HIPAA Privacy Rule (45 C.F.R. § 164.524);
- ◆ Make protected health information available for amendment and incorporate any amendments to protected health information in accordance with the HIPAA Privacy Rule (45 C.F.R. § 164.526);
- ◆ Make available the information required to provide an accounting of disclosures in accordance with the HIPAA Privacy Rule (45 C.F.R. § 164.526);
- ◆ Make its internal practices, books, and records relating to the use and disclosure of protected health information received from the Plan available to the Secretary for purposes of determining compliance by Plan with the HIPAA Privacy Rule; and
- ◆ If feasible, return or destroy all protected health information received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which the disclosure was made, and if destruction or return is not feasible, to limit further uses and disclosures to those purposes that make return or destruction of the information infeasible; and
- ◆ Ensure the adequate separation between the Plan and the Plan Sponsor.

With respect to electronic protected health information, the Plan Sponsor further agrees to:

- ◆ Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of any electronic protected health information that the Plan Sponsor creates, receives, maintains, or transmits on behalf of the Plan;

- ◆ Ensure that the separation between the Plan and Plan Sponsor is supported by reasonable and appropriate security measures;
- ◆ Ensure that any agents to whom it provides protected health information received from the Plan agree to the same restrictions and security measures that apply to the Plan Sponsor with respect to such information; and

Report to the Plan any security incident, as defined by 45 C.F.R. § 164.304, of which the Plan Sponsor becomes aware.

Any protected health information disclosed by the Plan will be disclosed to Barbara Drapola, Vice President of Operations and Clinical Affairs, the Vermont Managed Care: Client Account Representative, Information Analyst, Medical Director, Nurse Case Manager, Reimbursement Analyst, Provider Relations Representative, John Herko, Manager Benefits, the Fletcher Allen Health Care, Benefits Department: Benefits Administrator and Benefits Specialist designated by the Plan Sponsor. The Plan Sponsor will restrict access to and use of protected health information to those individuals who need it to perform plan administration functions. The Plan Sponsor will provide an effective mechanism for resolving any issues if such persons use or disclose your protected health information inappropriately.